What do therapists perceive are the enablers and barriers to working with transgender clients?

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Declaration

This work or any part thereof has not been previously presented in any form to the university or any other body whether for the purpose of assessment, publication or for any other purpose (unless otherwise specified). Save for any express acknowledgements, references and / or bibliographies cited in the work. I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

Signature:…….

Date:…….

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a successful conclusion; an outcome that would have been, literally, impossible without you.

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Abstract

This research aimed to explore what therapists perceive are the enablers and barriers which can arise when working with transgender clients. Some research studies have previously been carried out exploring the client's experiences of the therapeutic process, with a large proportion finding the counselling profession to be wanting. However, there is a dearth of literature exploring the reasons behind this from a clinical perspective, including potential ways of addressing the issues raised.

This qualitative study explored the perspectives of five experienced clinicians, from varying backgrounds who work therapeutically with transgender clients. The participants recognised that while there is positive work occurring within the field, there remains room for growth and improvement across all services including medical, social, psychological and legal. Due to the role and impact of individuation, personal beliefs and experiences, background and therapeutic approach, a Thematic Analysis as carried out on the data gathered from semi-structured interviews. The resulting themes highlighted the role of self-disclosure, training, the theoretical approach utilised and the use of language were all considered to be key elements; which can have a significant impact on the therapeutic relationship and subsequent outcomes. These themes were considered with reference to the implications both as an enabling and barrier on therapeutic outcomes and for Counselling Psychology practice.

Contents

List of Tables

List of Figures

Chapter 1 – Introduction

1.1 Overview of Research Report

The research dossier will aim to illustrate how, as a Counselling Psychologist in training, the opportunity was taken to conduct a piece of research which is forward focused and has the intent of making a positive contribution to the field of Counselling Psychology. The research aims to investigate both the enabling and limiting factors practitioners encounter when working with transgender clients. The research will explore several possible factors such as the need for additional Continuing and Professional Development Training (CPD) and how practitioners can/will navigate the balance between core and specialist competencies and skills.

Although at present, there is no single agreed definition, the term transgender refers to people who may have experienced dissonance and distress about the gender assigned at birth (cisgender). Particularly when there is enough to consider, decide upon and enact a process intended to alter their cisgender and, possibly, some of the associated physical characteristics. The aim being for their gender presentation to align with their gender identity (Richard & Barker, 2013). According to the Gender Identity Research and Education Society (2018, p.3), the term transgender is "*an umbrella term describing all those whose gender expression falls outside the typical gender norms. It is often the preferred term for those who change their role permanently, as well as others who, for example, cross-dress intermittently for a variety of reasons including erotic factors (also referred to as transvestism)*". People with transgender identities are not a homogeneous group, and they can be described and give expression in diverse ways, with a range of terminology being used. For example, transsexual, gender-queer (GQ), gender-fluid, non-

binary, gender-variant, crossdresser, genderless, agender, nongender, third gender, two-spirit, bi-gender, trans man, trans woman, trans masculine, transfeminine and neutrois (Stonewall, 2017). Please see the Glossary (Appendix A) for further explanation of the terms. Scientific and popular literature has abbreviated the term to 'trans' however, the full term of transgender will be used throughout, to ensure clarity about whom the research is referring to. An awareness of the diversity and heterogeneity of transgender people underpins the research and the role of terminology, definitions, and their evolution is explored within the literature review.

The research idea evolved from the personal experience of working within a service where the clinical team were hesitant about working with a new client who identified as Male-to-Female (M-t-F) transgender (Client A). The basis for the hesitancy was on a clinical and service level. Clinically, Client A's presentation appeared to be outside the clinician's professional frame of reference and more general cultural norms. Muller (2013, p.1) recognised that "*lesbian, gay, bisexual and transgender (LGBT) have specific health needs*" with many patients regarding healthcare professionals' attitudes as prejudicial therefore creating situations which can lead them to feel unsafe (Beehler, 2001; Eliason & Schope, 2001; Muller, 2013). From a service perspective, considerations were needed surrounding the following issues: how to integrate Client A into an inpatient facility; which gender ward would they be best placed on; policy amendment; addressing potential conflict; stigmatisation and care considerations required to meet Client A's needs. Post-admission it also became clear there were cultural and ethical issues that needed to be addressed with the nursing team meeting Client A's physical health needs, as a proportion of the nurses felt conflicted about working with a patient diagnosed with Gender Dysphoria. Walton and Baker (in press) argued a need for specific guidelines for

both inpatient and residential services on how to manage such cases, particularly in relation to some of the issues as mentioned above and dilemmas.

Beehler (2001, p.3) noted that "*health professionals are not immune to prejudice".* It would be unrealistic to argue that any professional has no prejudices, pre-conceived cognitions or cultural biases which influence how they work with clients, either beneficially or adversely. These were evident in the service in which I was working, and it made me consider my influences/biases and how they may affect my client work. Before meeting and working with Client A, I had limited knowledge of the transgender community, processes involved in seeking transition and confirmation of a person's true identity and if there needed to be any therapeutic considerations. Despite having no prior knowledge, I do not believe I had any negative attitudes or biases which would affect my ability to work therapeutically with Client A. I was raised to be open-minded, accepting and to embrace everyone from all walks-of-life as individuals regardless of religion, sexuality, gender, ethnicity, background and life choices. In relation to life choices, I was taught to accept that everyone has their path to walk, their own experiences, both positive and negative, 'demons' to fight, hopes and dreams and whilst that path may differ from my own, as long as they are not harming anyone, how can I judge them? These values were instilled in me from a young age, and these culturally induced beliefs are a life principle that I try and hold fast to.

Counselling Psychologists are ethically compelled to accept and respect others and their diversity, which resonates with the core conditions as outlined by Rogers (1957), which are necessary for psychological change within clients. Gelso and Kanninen (2017, p.330) argued that neutrality is a core component for effective therapy and noted that it must be carried out with "*empathy, caring and affirmation*". Furthermore, Brown (2010)

cited the importance of recognising the systemic principles of neutrality, circularity, curiosity and progressive hypothesising in the facilitation of a "*collaborative, empathic and reflective*" conversation (Flaskas 2002, p.43, cited in Brown, 2010). This meant I respected the nurses' perspective and opinions, despite them not fully-aligning with my own principles, supporting them when necessary and used the learning as further motivation for this research.

In addition to prejudices, clinical competency was another issue raised by the Multi-Disciplinary Team. In particular, members of the psychology department felt their clinical training had not rendered them competent to work with Client A, and they required specialised advice/support, seemingly due to a fear of 'getting it wrong' and having no knowledge of the transition[1] process which Client A was embarking upon. The transition process can take many forms (See Figure 1) and include legal components, psychosocial, hormone therapy and possibly surgery, it recognised the

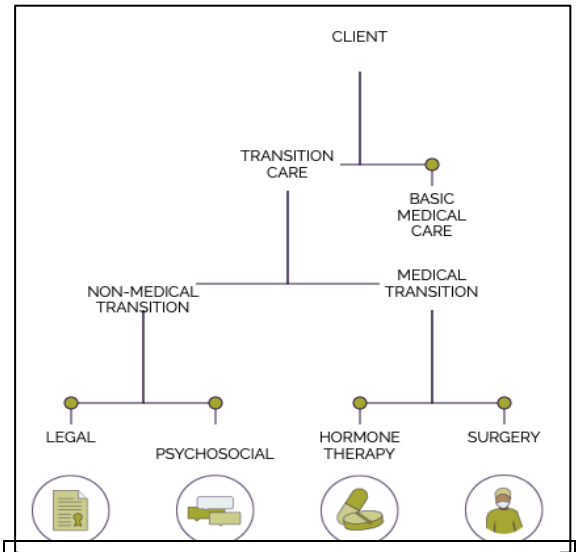

Figure 1: Overview of components involved in transitioning for transgender or gender diverse clients.

Reprinted from 'Trans Primary Care', by K. Speck, 2016, Retrieved from https://www.rainbowhealthontario.ca/TransHealthGuide/credits.html. Copyright 2016 Kelly Speck.

[1] **Transition** – the altering of "one's birth sex is not a one-step procedure; it is a complex process that occurs over a long period of time. Transition can include some or all of the following personal, medical, and legal steps: telling one's family, friends, and co-workers; using a different name and new pronouns; dressing differently; changing one's name and/or sex on legal documents; hormone therapy; and possibly (though not always) one or more types of surgery. The exact steps involved in transition vary from person to person" (GLAAD, nd)

process is not linear, and each client has their own "*pathway, journey and end goal in actualising the expression of their true self*" (Speck, 2016, para 1). Concerns from the medical team pertained to possible contra-indications between Client A's psychiatric medication, their hormone therapy prescription and the viability of surgery and the after-care required.

It was not clear why the multi-disciplinary team felt their clinical skills were not transferable, as many of Client A's presenting difficulties were within their clinical competency and attributed as arising from life transitional experiences. These included significant changes to the environment, accommodation, age-milestones and relationships. Schlossberg (1981, p.3) recognised that adults are continuously experiencing transitions which can be "*positive and negative, dramatic and ordinary*", all of which stress can accompany. Understanding the role of transitions and subsequent adaptation, whether relating to gender or additional factors, is a key tenet of working effectively with clients, developing appropriate interventions and executing them. Schlossberg (1981, p16-17) posited that it is the "*goal of counselling psychology to develop preventive interventions, pretransition, as well as effective support and counsel for those in transition*". However, their reticence may have been due to Client A's forensic profile, age, reports of identity confusion over the years and level of risks displayed. There were further discussions within the team regarding Client A's primary diagnosis and where Gender Identity Disorder fitted within the clinical formulation. Challoner and Papayianni (2018) carried out a systemic literature review regarding the role formulation for Counselling Psychologists and noted a debate regarding the inclusion of multi-disciplinary teams within clinical formulations. The research questioned whether collaborative formulation's between clients and multi-disciplinary teams adds or detracts from the process, due to the potential influence of power and experience. Challoner and

Papayianni (2018, p.60) reflected on the importance of this consideration for Counselling Psychologists as we "*prize[s] the subjective experience of all parties*".

As a result of the complexities and ongoing discussions within the multi-disciplinary team regarding Client A, the consideration to bear in mind regarding formulation, the opportunity to learn and work with someone of their clinical presentation was exhilarating and a tremendous learning opportunity. This was not only due to their Gender Dysphoria, but also forensic profile, the compulsory requirements related to this and whether they would influence the therapeutic process. Although exhilarated by the chance to work with Client A and increase my skills, the prospect was also daunting. Fortunately, at this time, my supervisor (also a Counselling Psychologist), embraced my thirst for knowledge, passion and, ultimately, my work to make a positive change with clients. Her unyielding support instilled confidence within the service that I was 'up-to-the-task' of working effectively with Client A, which prevented me from feeling alone and 'outside' of the team and instilled confidence within me, thus making the process less daunting.

I felt the best way to prepare for working with Client A was to carry out background reading to gain an understanding of Gender Dysphoria, treatment protocols/pathways, appropriate language/terminology and clinical guidelines before commencing therapeutic work. In addition, I needed to learn more about the forensic needs of Client A, both from a client and service perspective, along with the bearing this could have on the therapeutic process. During the preparatory work, it became evident that research indicated a higher rate of suicide risk for those choosing alignment surgery within the transgender community (Dhejne et al., 2011). This was relevant to Client A, as they were in the initial stages of seeking Gender Alignment Surgery and had a history

of engaging in self-harm behaviours, expressing suicidal ideation and making significant attempts on their life. As a result, this needed to be a key consideration in the therapeutic pathway and clinical management of Client A.

Prior to this research, I had co-authored several papers for a number of conferences on self-harm and suicide (See Appendix B for conferences) and worked extensively with clients presenting with similar risks. It is important to note I am mindful of my fortuitous position: having a supportive clinical supervisor; prior knowledge of recognising and working with risks; access to an MDT with a wealth of clinical experience and access to a range of resources, which further added to my confidence to work effectively with Client A. I believe my prior experiences and the above-noted factors led to the daunting feelings subsiding and not manifesting themselves as 'barriers' to the therapeutic work. However, I am mindful that someone without these resources and support could be hesitant to work with Client A resulting in barriers emerging for clinicians.

Throughout the preparatory reading, several relevant themes relating to the therapeutic work were identified, in terms indicating enabling and limiting processes. The American Psychological Association (APA) has since released '*Guidelines for Psychological Practice with Transgender and Gender Nonconforming Practice*' (APA, 2015), which encapsulated many of the themes my initial reading highlighted. These included an understanding that gender identity and sexual orientation are distinct but interrelated constructs. Furthermore, it stressed the importance of having an awareness of one's attitudes about, and knowledge of, gender identity and gender expression and the importance of recognising the influence of institutional barriers and assisting in overcoming them. It also emphasised the importance of understanding how mental health

concerns may or may not be related to a transgender person's gender identity, the psychological effects of minority stress and the need to aid in preparing psychology trainees in working competently with transgender people. In response to the latter, the APA recognises Gender Identity as a factor for which psychologists need to undertake training, experience, consultation, or supervision to ensure competent clinical practice (APA, 2017). These factors will be explored further in the literature review.

In addition to the above-noted themes, there were a number of other fundamental questions to consider when working with Client A. For example, how to write reports which includes a person's clinical history prior to them transitioning, whilst maintaining respect for their transgender identity; when scoring psychometric assessments, which norm scales to use; how to address the attitudes of healthcare staff and other service users; addressing the stigmatisation within psychiatric services and the implication and effects of 'minority stress'. The dearth of forensic assessments ascertaining the risk and treatment of transgender individuals is acknowledged. Also, the assessments which are available for forensic populations *"are normed on cisgender populations with no special considerations for transgender or nonbinary populations*" (Webb, Heyne, Holmes, & Peta, 2016, para 9). Rood et al. (2016) also emphasised the need to recognise the impact of expecting rejection can have on transgender persons and its potential to exacerbate psychological distress.

As noted above, the therapeutic approach was person-centred. This approach recognises clients' resources and capacity to create psychological change if provided with the right conditions (Rogers, 1986). Gross (1992, p.905) added "*as no one else can know how we perceive, we are the best experts on ourselves*". The view that clients are the best expert on themselves, further confirmed being person-centred was the right approach with

Client A. A potential barrier, of which I was mindful, was that Client A was also under the care of external specialist gender services due to the desire to pursue medical transition. The primary concern was in relation to my lack of experience in this area and the prospect of our therapeutic work being under scrutiny from experts. It is possible these concerns may be viewed as barriers by therapists thus preventing them from working with transgender clients.

In summary, the process of working with Client A, the learning opportunity, the questions and concerns and the therapeutic work itself, ultimately led to the development of this research.

Milton (2010), argues that Counselling Psychology recognises the complexity of the human experience and engages with it to benefit all involved. Therefore, it is of paramount importance we examine and seek to understand the experiences of all and be open to how people's lives differ; even if that contrasts with our cultural norms and perspectives. The prospect of barriers hindering access to services and peoples' experiences not always being positive (Lev, 2004), did not sit comfortably with me as a Counselling Psychologist in training (See also Corliss, Belzer, Forbes, & Wilson, 2007; Ellis, Bailey, & McNeil, 2015; Ross, Law, & Bell, 2016). As this is a direct contrast to the fundamental principles of Counselling Psychology, whereby any work should be with the intention of beneficence and non-malevolence and that 'relational perspectives' are fundamental to work towards a greater understanding of people and ultimately overall happiness (Milton, 2010).

McAteer (2010), argued it is the role of Counselling Psychologists to eschew dogmas, embrace curiosity and question the assumptions of life and practices. In addition, Rafalin (2010, p.3), noted it is these opportunities and perspectives which are vital to

Counselling Psychology as the discipline seeks to answer the "*burning questions",* and respond to the call for 'scientific evidence' to support clinical choices while valuing the "*subjective phenomenological experiences*" of their clients. As a result, the ability to integrate the role of researcher and practitioner effectively can be challenging, particularly when discussing potentially sensitive topics which the author is passionate about and ensuring the participant's voice (clinician) is not lost within the process. Throughout the preparatory work with Client A and this research, I have explored my assumptions and beliefs regarding those who identify as transgender and whether my curiosity and beliefs have helped or hindered the therapeutic and research process. However, in summary, and as clichéd as it may sound as if my beliefs are simple. The complexities and variations of life are what makes the world an interesting place and everyone within it deserves to find happiness and psychological peace. If in order to achieve this, someone alters their gender identity, it serves to add to the rich tapestry of life. Fundamentally for me being a Counselling Psychologist, means making a positive difference in someone's life and the core conditions aid in the facilitation. The research also aims to have a role in this.

As a result of the risk indicators identified when undertaking the preparatory work for Client A and previous research undertaken, the initial research aim was to explore the risk factors which lead to an increase in vulnerability to self-harm and suicide within the transgender community. However, this encountered some difficulties, including the ability to recruit sufficient participants from both clinicians and members of the community. This resulted in the garnering of rich data, but unfortunately, it only gave a voice to therapists and not transgender clients, nor truly highlighted any potential vulnerabilities. Mwangi, Chrystal and Bettencourt (2017, p.4) acknowledged qualitative research should balance "*breadth and specificity*", with researchers wanting to solve a

"*major problem*" but due to the "*complexity of that problem, the study may not be able to solve it*". They also note that research question development can be an iterative process, leading to revisions as the study and data emerge. This was true of this study, leading to refocusing the final research question to reflect the participants' stories, thoughts and feelings.

As a researcher who is passionate about giving a voice to others and those marginalised within society, it was difficult to accept and acknowledge the initial research had missed its intention. Considerable reflection, questioning of self and the research led to further reading and a more extensive review of the literature. The outcome was confirmation that knowledge and expertise, along with understanding and awareness of the unique issues gender variance presents (Mizock & Fleming, 2011) within Counselling Psychology is limited. As a result, we are not always meeting the needs of the transgender community. The period of reflection was difficult and promoted a revision of the research questions and focus. In light of this, the renewed research aim is to carry out a *'qualitative exploration of therapists' experiences of working with transgender clients,'* with a focus on '*what therapists perceive are the enablers and barriers to working with transgender clients?'*

Milton (2010, p.xxiii) argues research should elucidate the significant contributions we, as Counselling Psychologists, can make to therapeutic practice, research, policy development and so contribute to the betterment of society. It is anticipated that the research will yield rich data illustrating the enabling factors and barriers therapists face when working with transgender clients and offer insight on how to overcome them. Furthermore, within the field of psychology, the research holds the potential for positively influencing clinicians' practice and clients' experiences. This

research is original in many ways, including hearing the voice of therapists from a range of disciplines which currently work with the transgender community and having knowledge of clients' past and present therapeutic experiences.

1.2 Research Dossier Structure

The research concentrates on the narrative of clinicians in relation to their therapeutic work and is an exploration of their experiences of working with transgender clients. It aims to investigate the considerations which need to be borne in mind when working with transgender clients and the potentially supportive factors, as well as obstacles to working successfully with the cohort. Therefore, the ensuing research question is posited:

What do therapists perceive are the enablers and barriers to working with transgender clients?

The structure of the research dossier is within the scientist-practitioner model, which the British Psychological Society notes as a central component of psychology within the UK (British Psychological Society, 2011). Belar and Perry (1992, p.72) argue that working within the scientist-practitioner model produces a psychologist who is "*uniquely educated and trained*", who is *"capable of functioning as an investigator and as a practitioner, and may function as either or both, consistent with the highest standards in psychology".* In addition, there is the aim of future publication, in order to disseminate the empirical knowledge and further benefit the field of Counselling Psychology. Rafalin (2010) notes that a defining principle of Counselling Psychology is its driving concern to engage with people and recognise each individual's' unique experience. This research aims to illustrate this further.

Chapter two: The **Literature review** commences with contextualisation of the transgender community within current research, an overview of the terminology, the role of language, culture, social assumptions, therapeutic considerations, training needs and the different forms of transitioning and treatment approaches. The literature review also incorporates an overview of historical perspectives and its current position within medical and therapeutic models, thus providing a context of potential difficulties therapists/clients may face and factors which enable the process.

Chapter three: The **Methodology** section will present an overview of Social Constructionism theory which underpins the research question within the methodological framework of qualitative enquiry. The chapter will also provide an overview of the chosen analytical framework – Thematic Analysis, participant recruitment and the ethical considerations considered. Finally, the chapter will explain how the data was collected, processed and analysed.

Chapter four: The **Research findings** chapter will provide a profile of each research participant, emergent themes from the raw data contextualised within the participants' narratives.

Chapter five: The **Discussion** chapter outlines the research findings within the context of the literature review, together with concluding comments and recommendations for further research.

Chapter six: The **Reflective Appraisal** chapter, encapsulates the journey of the research and researcher. It will provide insight into the highs and lows of the research journey and how the process has shaped me both as a researcher and a practitioner. The chapter will also explain how the process has significantly influenced me on a personal

level, and as the person I am today. It is the objective of this chapter to convey the passion behind the research and the hope to make a difference on albeit a micro or macro level within the field of psychology.

The thesis concludes with references and appendices.

Chapter 2 – Literature review

2.1 Introduction

The World Health Organisation in June 2018 announced Gender Dysphoria would no longer be classified as a mental health disorder within the International Classification of Disease (ICD-11). In the same year, BMJ reported there had been a 240% increase in the number of persons seeking support for their Gender Identity over the past five years (BMJ, 2018). Palmer (2018, cited in BMJ, 2018, para 2) stated the increase has been unprecedented and "*No other specialised service has seen this growth*". He added due to the increase in demand there was "*not sufficient capacity in the system*" (Palmer 2018, cited in BMJ, 2018, para.2) to cope with all the referrals.

Olson-Kennedy et al., (2017, p.2) noted while there have been substantial developments in the last two decades about understanding needs and approaches to care, "*many questions have remained unanswered*", with emphasis on transgender youth. Wanta and Unger (2017) added there remains a dearth in academic research focusing on the needs of transgender clients and their care. Mueller, Cuypere, and T'Sjoen (2017) argued this is not the case and progress has been made in "*characterizing the needs of transgender persons wishing to transition to their preferred gender, thus helping to optimize care".* A review of the literature in 2011, found transgender-specific articles and research accounted for only "*2.66% of all lesbian, gay, bisexual, and transgender (LGBT)-related articles*" (Snyder, 2011). Richards (2016, p.23) noted that the lack of literature has a negative impact on Counselling Psychologists being able to access "*simple, quality information"* which informs their practice.

Pollock (2015, p.1) recognised when researching topics about transgender issues, it is vital to be led by the community and have an awareness of how language is used and how it can be "*politicised*" and is "*often changing in acceptability*". Towle and Morgan (2002, as cited in Stryker & Whittle, 2006, p.667) also reported transgender people are often upset, and their *"lives and identities are violated and misrepresented for the goals of scholarship*". Due to such reports, the researcher was mindful of this throughout, especially as they were also an outsider to the transgender community. However, it was felt carrying out a respectful piece of research could be achieved, with the aim of exploring the enabling and barrier factors clinicians perceive when working with transgender clients, in order to increase the effectiveness of therapeutic services if accessed.

Trans Media Watch (2010-2015, p.3) acknowledges the term 'trans' is an umbrella term which can be used to describe those who "*need to present themselves as and who identify as other than the gender they were assigned at birth*". Furthermore, the term transgender is applicable when the reader/audience may be unfamiliar with the term 'trans' (Trans Media Watch, 2010-2015). Given this, throughout this research, efforts were made to utilise current language and best practice. Previously accepted terminology within the context of prior research has been cited and at these times been made explicit. It is important to note in these instances the terms may not align to current preferred or modified language and have been included not to offend but to ensure a comprehensive overview and to illuminate changes in thinking.

This chapter will explore the factors which therapists perceive to be enablers or barriers to working with transgender clients including benefits and implications of changing terminology/language, the medical and social model, assumptions, stigma and

beliefs, standards of care and the role of training. This achieved through a comprehensive literature review which will establish a theoretical framework for the research and place it within the context of the broader field of relevant information. It is important to note, that it is outside the bounds of this research to explore all the facets in depth. However, it is the researchers aim to highlight the complexity of the topics mentioned above, show how knowledge and understanding in the academic and therapeutic community have evolved, in parallel with changing social norms and attitudes towards gender transition.

2.2 Process of carrying out the Literature Review

Webster and Watson (2002, p.13) stated that carrying out a literature review is crucial for academic research and "*creates a firm foundation for advancing knowledge. It facilitates theory development, closes areas where a plethora of research exists, and uncovers areas where research is needed*".

The search for relevant information from bibliographic databases was extensive and included many key terms including their synonyms as this ensured all potentially relevant documents were sourced (See Appendix C). Besides this, a number of other research techniques are utilised including: 'wildcard' features to ensure words which are spelt differently depending on the country of origin and organisation were included, e.g., counsellor and counsellor. 'Truncation' which ensured all relevant material using the same root are searched, e.g. trans* would bring us transgender, transgenderism, trans and transgendered and 'boolean operators' which combines topic areas to either narrow or broaden the documents searched.

To understand the broader context additional documents were sourced and read including *equalities act, the Human Rights Act, Gender Recognition Act, World Professional Associate of Transgender Health – Standards of Care and Declaration of Sexual Rights*. Along with understanding the role of secure identity and healthy intimate relationships in wellbeing, morbidity and mortality. Further searches were carried out, following the reading of articles, journals and books and cited literature.

Searches were conducted using the University of Wolverhampton library, electronic databases and Summons. These included: Academic Search Complete, Informaworld, PsychARTICLES, EBSCO Host Research Databases, PsycBOOKS, ScienceDirect Journals, Wiley Online Library, Wiley InterScience Journals, Academia, Scholar Google and Google were also used. The University library was used to access books, electronic books and articles and the online store Amazon, was used to purchase books.

Following the identification of literature, the quality of research was evaluated using the Critical Appraisal Skills Programme (CASP) tools (Critical Appraisal Skills Programme, 2015)**.** This allowed for a structured assessment and review of each document's rigour, merit and applicability to the research to ensure a systematic and robust review is achieved. Consequently, research papers which performed well on the CASP quality assessment inherently received more emphasis within the literature review and subsequent write-up. Therefore the CASP was used to categorise the identified literature in terms of a hierarchy of relevance and applicability to the current research. As a result, some papers which did not score highly were not automatically discounted, as some still contained applicable and relevant information to the current research.

2.3 Terminology, definitions and language

In order to outline and contextualise the changes in terminology and language relating to transgender, it is essential to understand the conceptualisation of the term, usage over time and the difference between a person's gender, gender identity and sexual orientation (Also see Glossary – Appendix A).

Trippe (2015) stated that despite an array of research and literature, lack of understanding and stigmatisation has remained regarding transgender experiences, with an emphasis on language. She added, to understand transgender experiences, there has to be an awareness of the differences between gender, sex and sexuality. Little (2016) and Tollinche et al., (2018) stated there is a clear distinction between the concepts of sex and gender. He defined a person's sex as physical or physiological differences between males and females. Furthermore, he argued for a clear distinction between sex and gender. This allowed for exploration and understanding of gender and sexuality as social variables and not a biological one; he also added the terms could not be used interchangeably. Additional theories regarding gender identity development have been postulated in recent years including whether there is a sexual differentiation between the human brain in relation to gender identity (See Savic, Garcia-Falgueras, & Swaab, 2010).

In reference to gender and sexuality, Richards and Barker (2013, p.1) stated the terms are "*complex and contested, to the point at which no definition adequately encompass them*". They refer to gender as "*a person's sense of their own identity in relation to being a man or a woman, or identity beyond this conventional gender dichotomy*" (Richards & Barker, 2013, p.3). Richards and Barker (2013, p.3) added that sexuality refers "*to types of sexual attraction, identity and practice as well as to people who do not experience attraction*". Diamond (2002), noted that a persons' gender identity

is based on the extent to which they identify as either masculine or feminine. Barker (2017, p.8) argued "*gender, sexuality and relationships are inextricably linked"* and advocated for them being recognised as such and not separate.

2.4 Historical overview of the terminology

Ekins and King (2006) reported that the terminology surrounding transgender is less than 50 years old and established in the 1970s. Rawson and Williams (2014, p.3) stated [one of the difficulties in tracing the history of the term is due to its "*lexical compound*". They added although the term transgender and its "*suffixes have prevailed in contemporary usage*" (Rawson and Williams, 2014, p.3), historically the term has also included alternative incarnations: transgenderal, transgenderist, and transgenderism.

It is widely perceived that Virginia Prince coined the term 'transgender' and its derivatives in December 1969 in her magazine 'Transvestia' and referred to those *"like herself who "elected" to live full-time and permanently as women"* (Ekins & King, 2005, p.2). It is further reported Prince coined the term "*transgenderal*" (Prince 1969, p.65), in the 1950s however this proved to be unpopular, and later changed to "*transgenderist*" (Prince 1969, p.65), by 1978 which included transvestites and transsexuals. Ekins and King (2006) stated that Prince referred to this term as referring to those who are undergoing or considering undertaking surgical interventions of changing sex. For Male-to-Female this refers to those who adopt the *"the exterior manifestations of the opposite sex… without any surgical interventions*" (Prince, 1978, p.86). Gherovici (2018) stated the term 'transexualis' was used before this by Cauldwell in 1949 and referring to

"*individuals who wish to be members of the sex to which they not properly belong*" (Cauldwell, 1949 cited in Stryker and Whittle, 2006, p.275).

Sam (2010, p.13) argued the prominence of transgender, transsexuality and transvestism were "*circumscribed by the authorities of medicine, psychiatry and law".* Within the medical field, the first publication of the term remains contested. Rawson and Williams (2014) noted that John. F. Oliven documents the earliest evidence of the lexical compound (trans+gender) in his 1965 book titled "*Sexual Hygiene and Pathology"*. Oliven (1965, p.514) defined it as the point "*Where the compulsive urge reaches beyond female vestments, and becomes and urge for gender ('sex') change, transvestism becomes 'transsexualism*". However, Hirschfeld was cited as noting the term in his 1923 German article "*The Intersexual Constitution" ["Die intersexuelle Konstitution"] (Hirschfeld 1923)"* (Kollen, 2016). Sam (2010) stated Hirschfelds' term "*signalled a radical departure from earlier medicalised conflations of the behaviour into homosexuality*".

Rawson (2015, para 9) stated within the first five years of usage, *"the term took on new, even opposite meanings",* meaning by the current definition Prince would be "*lumped together with the very people she sought to distinguish herself from in the first place*" (Rawson, 2015, para 11).

2.5 Current usage as an 'umbrella' term

Due to the lack of agreement on a fixed or singular meaning, Davidson (2007) the term transgender is used as an 'umbrella term'. The use of an 'umbrella' term ensures inclusivity of identities, sex and gender variance (Barker, 2017; Beemyn & Rankin 2011; Bioldeau, 2005; Johnson, 2007; Morgan & Stevens, 2008; Riggle, Rostosky, McCants,

& Pascale-Hague, 2011; Ross, 2014; Trippe, 2015). Bettencourt (2009) created an infographic to illustrate this further – See Appendix D. Ekins and King (1997) posited increased diversity recognised under the transgender umbrella led to an increase in the feeling of unity. Barker (2017) noted social media sites offer more than 70 gender terms for users to choose from, highlighting continuing expansion and recognition of gender diversification.

As a result, the term currently has been used to encompass those who identify with a range of gender identities and expressions including trans, transsexual, gender-queer (GQ), gender-fluid, non-binary, gender-variant, cross-dresser, genderless, a-gender, non-gender, third-gender, two-spirit, bi-gender, transman, transwoman, trans-masculine, trans-feminine, Neutrois, pre-, post-, and non-op transsexuals, gender queer, gender outlaws, transvestites, drag queens, impersonators and 'gender benders' (See Bioldeau, 2005; Brown & Rounsely, 2003; Devor, 2002; Ekins & King, 2006; Human Rights Campaign Foundation, 2016; Johnston, 2016; Keo-Meier & Labuski, 2013; Leli & Drescher, 2004; Stonewall, 2017; Teich, 2012). Rawson (2015, para.13) argued while an 'umbrella' term may be regarded as positive; at times, it has been applied *"anachronistically"* and applied too broadly which can present challenges. Lane (2009) also raised the concern that there is a risk that voices could be silenced or erased due to the use of an umbrella term. Rawson (2015) argued that the inclusive nature of the term means it also runs the risk of minimising identities and experiences and including people who would choose not to be described by the term. The ambiguity over the terminology regarding people who identify as transgender has inevitably led to an increased confusion for individuals who consider themselves along the 'gender spectrum.'

2.6 Language

Trans Media Watch (2010-2015, p.2) argued: "*language surrounding trans issues has become unnecessarily complicated and is often inappropriately focused on intimate medical* detail". To add further complexity the acronym LGBT (lesbian, gay, bisexual and transgender) has been criticised due to the assumption they are a *"homogenous group with coextensive health issue*" which can lead to "*inaccurate conclusions*" (Wylie & Wylie, 2016, p.10) within the literature (Also see Davy & Siriwardena, 2012). Also, the media reports a growing discord within the community, with some petitioning for the 'T' to be removed from LGBT. Chase (2015, para. 2) cites the crux of the argument as laying with the fact "*the L, G and B are about sexual identity; the T is about gender*", therefore "*lumping the four initials together only enhances the misperception that they are interchangeable terms*".

Mizock and Fleming (2011) noted gender and sexuality had historically been combined and viewed/approached therapeutically as the same, which has served to create and perpetuate a lack of awareness regarding gender variance and its associated difficulties. Poteat, German and Kerrigan (2013, p.23) added there is also risk research may "*underestimate transgender discrimination*" as studies have found *"attitudes towards trans people are significantly less favourable than towards LGB individuals".* Therefore, it could be argued confusion about language, fear of inadvertently causing offence and/or discriminating and the lack of clarity in the research could potentially be a barrier for clinicians working with transgender clients which in turn may influence transgender clients accessing service.

Mendonsa (2012) acknowledged the terminology could evoke strong reactions and therefore the literature recommends clinicians always seek their clients' preferred term.

This view was further supported by Trans Media Watch (2010-2015), who also noted an added complexity stating, "*words occasionally used within the trans communities may be unacceptable outside them*", thus potentially creating further barriers for clinicians'.

A further important consideration lies in the language used by therapists. Moon (2008, cited in Barker 2017, p.15) reported the language used "*often belies implicit biases against those who are marginalised*" even by those who view themselves as affirmative clinicians.

2.7 Prevalence and culture

The terminology may have varied and evolved, but regardless of the definition, references to transgender persons are evident throughout history and across different cultures. For example, Koh (2012, cited in de Fin de Grado, 2015, p.12) reported within Greek mythology those who desired "*to live as though they have the opposite gender"* were recognised.

In the 1770's French Diplomat Chevalier D'Eons' was born male but dressed and lived as a woman for more than thirty years and spoke of travelling on a diplomatic mission to Russia under the name of Lia de Beaumont (Burrows, Conlin, Goulbourne, & Mainz, 2010). Another historical reference can be found in the Native American culture who do not have set gender rules and acknowledge a spectrum of identities which include *"female, male, two-spirit frame, two-spirit male and transgendered"* (McKinney, 2016, para.3). Those who identify as two-spirited are viewed as being *"gifted by nature"* (McKinney, 2016, para.3) and revered as *"religious leaders and teachers"* (Williams, 2010, para.3). Reicherzer (2008, p.327) added before the 1950's *"experiences of gender*

blending [had] historically been revered, or at the very least, grudgingly tolerated as lived experiences of important religious purpose". Cohen-Kettenis & van Goozen (1997), postulated those who identify as transgender are least accepted and tolerated by the Western World.

Current research estimates the prevalence of people identifying as transgender worldwide is "*in the order of 1/37,000 of the general population for male to female (MtF) and 1/100,000 for female to male (FtM)"* (Delahunt, Denison, Sim, Bullock, & Krebs, 2018, para.3). However, Collin, Reisner, Tangpricha and Goodman (2016), stated that caution needs to be taken about prevalence rates as they can vary considerably depending on the definition used. Barker (2017) also added that prevalence estimations are difficult as a person may no longer identify as transgender following transition and many do not go through transition, further affecting the reliability of statistics.

TGEU (2015, para.1) noted that 34 countries in Europe continue to prevent a "*trans person to change their name and registered gender without invasive and abusive requirements that violate their human rights*". Research has shown the lack of legal recognition for those who identify at different stages of the 'gender spectrum' and in particular transgender, can be an indicator of vulnerability towards suicide (Bauer, Scheim, Pyne, Travers, & Hammond, 2015). Also, a further vulnerability towards self-harm and suicide can be due to the *"burden of stress"* they experience due to confusion from friends, family and others around them (Moskowitz, 2010, para.5). Therefore, could fear of using incorrect language/terminology be perceived as barriers facing clinicians' working with transgender clients?

A further consideration is concerning clinicians and their generational frame of reference/backgrounds and how this may differ from clients.' Barker (2017, p.10)

recognised the importance of this and how understandings have "*varied across time and place*", which may affect understandings of experiences. She later provided the example of gender transition and how in some cultures it is accepted more than 'same-sex' attraction, which may result in people "*opting for transition rather than facing criminalisation or even death penalties for homosexuality"* (Barker, 2017, p.12). Cavanaugh and Ladd (2017) also commented on the disparity that can arise between clinicians and research findings, due to them already being qualified and practising and the need to 'bridge' the gap which can arise.

2.8 Terminology and the current research

Throughout this paper, the term 'transgender' is used as the descriptor for people who feel the gender, assigned at birth does not align with their gender identity. The Gender Identity Research and Education Society – GIRES (2018) recognise the changing terminology within the literature regarding transgender and note it is "*varied and constantly shifting as understanding and perceptions and awareness improves*" ("Terminology – Gender Identity Research & Education Society", 2018, para 1). They added the term has "*had different meanings over time, and in different societies*" and currently is used as an "*umbrella*' 'term "*describing all those whose gender expression falls outside the typical gender norms*" ("Terminology – Gender Identity Research & Education Society", 2018, para 12).

2.9 Social assumptions, stigma, beliefs

Barriers facing clinicians' working with transgender clients has been evident since the media first highlighted the case of Michel Dillon (1946) in the United Kingdom and later of Christine Jorgensen (1952) in the United States of America (Kennedy, 2007). Jorgensen's' transition made headline news in the New York Daily News in 1952 with the headline *"Ex-GI Becomes Blonde Beauty"* (Drescher, 2010, p.111). It is important to recognise the difficulty in achieving the necessary surgeries during the early 20th Century, as performing them was illegal in many countries. In relation to Michel Dillon the illegality stemmed from the 18th Century 'Statute' in English Law, which prohibited the *"disabling, disfiguring or cutting off or making useless one of the members (leg, arm, penis, hand, foot, eye) of another intentionally or in a fight"* (mayhem, n.d, para.1). Kennedy (2007, p.16) stated, as a result, the statute prevented surgeons in England and the United States of America from performing surgeries, deemed as contravening the Mayhem statute on a *"man who could be drafted as a soldier".* Also, physicians at the time believed people who identified as transgender suffered from a psychological condition (Kennedy, 2007). Therefore, physicians would be in breach of the Hippocratic Oath (first do no harm), if they carried out the removal of healthy organs for *"non-prophylactic reasons"* (Hume, 2011, p.42). Richards and Barker (2013, p.38) note that previously many within the medical field have "*put their livelihood and profession on the line to fight for trans services*" and it is the same professionals who once "*vilified trans people in the past*" are now promoting positive change.

2.10 Therapeutic considerations: Medical model vs Therapeutic model

2.10.1 Medical Model

Discussions and the evolution of medical practices relating to transgender have been ongoing since the early 1900s, with references made to its "*medical and scientific roots"* (Sam, 2010, p.16). Sam (2010, p.16) also argued pioneers such as Magnus Hirschfeld, Havelock Ellis, Harry Benjamin and John Money, have "s*haped and advanced medical and psychiatric knowledge on transgender*". Due to its origin from the fields of sexology, medicine and psychiatry, Gender Identity Disorder was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM III) since 1980 (Draper & Evans, 1997).

Hume (2011) stated there are a number of people advocating for reclassification/removal of transgender as a psychiatric condition, and argue it is not a "*mental disorder, but rather a physical problem which can be alleviated by means of a combination of physical therapies designed to change the body*" (Hume, 2011, p.38). Before its inclusion within the DSM, Callahan (1973, cited in Hume, 2011, p.43) was arguing against the *"medicalisation of the human condition"*. Robles et al. (2016, p.850) argued: "*The conceptualisation of transgender identity as a mental disorder has contributed to precarious legal status, human rights violations, and barriers to appropriate health care among transgender people*". Moser and Kleinplatz (2006) noted the classification of gender and sexuality as a mental disorder further perpetuates the idea of it being pathological and non-conventional. Throughout recent years, the debate surrounding classification of transgender as a psychiatric condition has increased and is gradually changing with the World Health Organization proposing to declassify "*transgender identity as a mental disorder*" (Canady, 2016, p.6) in 2018 from 'Mental

and Behavioural Disorders' to 'Conditions Related to Sexual Health'. This has been widely accepted due to the new proposed chapter being more medically orientated.

Dr Paul McHugh, a former psychiatrist-in-chief at the John Hopkins Hospital (the first medical institution in the U.S to offer re-assignment surgery in the 1960s), has disputed reclassification and holds the view it is a "*mental disorder"* (Chapman, 2015, *para.1).* Richards and Barker (2013, p.38) noted classification of Gender Identity Disorder within mainstream psychiatric taxonomies had permitted access to "*NHS funding in the UK and insurance funding elsewhere*". The Human Rights Campaign (2004, cited in Devaney, 2005), also recognised inclusion within the medical model provides a degree of legal protection for people who identify as transgender, through the provision of hormones and access to surgeries. Bilodeau (2005) noted that a diagnosis must be documented, in order for surgeries to be carried out. Dewey and Gesbeck (2017, cited in Lee, Park, Choi, Yi, & Kim, 2018, p.10) added *"diagnosis plays an essential role in determining access to medical transition*". Furthermore, a diagnosis can serve as legitimising the *"clinically significant distress and impairment"* (Narrow, Kuhl, & Regier, 2009, p.88).

Richards (2016, p.15) reported that there continues to be considerable debate regarding the ongoing classification as a "*psychiatric taxonomy".* Robles et al., (2016) argued that the current classification of transgender as a mental disorder has contributed to the barriers facing transgender people. They argued reclassification of "*transgender-related health conditions in the ICD-11 could serve as a useful instrument in the discussion of public health policies aimed at increasing access to appropriate services and reducing the victimisation of transgender people*" (Robles et al., 2016, p.851). Bornstein (1994) and Meyer (2010) argued that classification as a mental disorder is

harmful to people who experience Gender Identity Disorder (GID). Meyer (2010, p.40) noted that transgender advocacy services strive for medical professionals to "*affirm that difference is not disease, nonconformity is not pathology, and uniqueness is not illness*".

Waszkiewicz (2006) indicated that within medical systems transgender people have consistently experienced inequality, discrimination and bias. This view is supported by Bockting, Robinson, Benner and Scheltema (2004), Lombardi (2001) and Lombardi and Van Servellen (2000), cited negative experiences and overt discrimination are a consistent feature when accessing medical care. Kenagy (2005) and Sperber, Landers and Lawrence (2005) reported transgender persons had experienced significant discrimination from healthcare providers, with some receiving "*humiliating treatment from providers and outright refusal to provide services*" (Sperber et al., 2005, p.85). Sheerin (2009, p.13) added the transgender community had viewed their relationship with mental health professionals as "*complex and at times contentious and controversial*". Lombardi (2001, p.869) noted the need for *"greater sensitivity"* and an increase within services for the transgender community. Feinberg (2001) also noted accounts of negative experiences permeate throughout the transgender community. Therefore, changes in classification, discussions of health policies and service accessibility could be an enabling factor for clinicians working with transgender clients; thus, positively changing the experiences of those accessing services.

Wylie and Wylie (2016, p.10), recognised for many practitioners their understanding of "*transgenderism may arise from familiarity with its inclusion within psychiatric classification systems*". They added "*knowledge and understanding of trans issues remains suboptimal*" (Wylie & Wylie, 2016, p.9) within clinical settings/healthcare services. A criticism of having a sole understanding from the medical model is it allows

for pathologisation and clinicians not focusing on underlying issues associated with Gender Dysphoria which includes depression and anxiety (Budge, Adelson, & Howard, 2013). Bouman and Richards (2013) argued while classification systems such as the DSM can aid in the facilitation of clinical care and certain countries allow access to insurance coverage for mental health difficulties; it can also be stigmatising and impact on how people are viewed, e.g. by themselves, others and society.

Brickman, Rabinowitz, Karuza Jnr, Cohn and Kidder (1982) noted when clients are seen from a medical model perspective, they are no longer seen as individuals, but as someone in need of treatment. Butler (2006, cited in Sheerin, 2009, p.14) argued including Gender Identity Disorder as a "*diagnostic category is a vestige of such pathologizing perceptions and remains an instrument of oppression*" and perpetuates stigma associated with gender non-conformity (Butler, 2006). White (2002) also argued that pathologisation in effect makes the client the mental disorder. Thus, potentially creating barriers within the therapeutic relationship

Whittle (2010) noted currently within the medical literature people who identify as transgender are regarded as experiencing distress due to a significant incongruence between their gender at birth and the one, they identify with. This incongruence can lead to a diagnosis of Gender Identity Dysphoria. The International Statistical Classification of Diseases, tenth edition (ICD-10) recognises Gender Identity Disorder (F64.0) as *"a marked difference between the individual's expressed/experienced gender, and the gender others would assign to him or her, and it must continue for at least six months"* (World Health Organisation (2016): F64 Gender Identity Disorders) and cites four categories: F64.0 - Transsexualism, F64.1 - Dual-role transvestism, F64.2 - Gender Identity Disorder of childhood, F64.8 - Other Gender Identity Disorders and F64.9 -

Gender Identity Disorder, unspecified (World Health Organisation, 2012). The diagnosis of Gender Dysphoria (DSM-V) and Gender Identity Disorder (ICD-10) have their own set of diagnostic criteria including different inclusion/exclusion criteria. The importance of the medical model is acknowledged, along with its role in psychiatry and psychological practice within the field of mental health. Jensen (2006) argued that a focus on the medical model is present within the therapeutic relationship as soon as contact is made and thus has a bearing on the therapeutic process. Therefore potentially creating a barrier to clients forming a firm therapeutic alliance due to concern about being pathologised.

The term 'transsexual' was first introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in the 1980s, along with the classification of Gender Identity Disorder of Childhood, Gender Identity Disorder of Adolescence and Adulthood, Non-transsexual Type (for people who do not wish to pursue sex-reassignment) and Gender Identity Disorder Not Otherwise Specified - for those who do not fulfil the criteria for specific Gender Identity Disorders. In the revised DSM-IV there was a change in the classification and only one diagnosis listed: Gender Identity Disorder (GID) and was viewed as an Axis I disorder, with an aetiology from a variety of *"different routes"* and *"with varying levels of intensity"* (Bradley et al, 1991, cited in Cohen-Kettenis & Pfafflin, 2009, p.499). One of the main criticisms of the DSM classification has been their approach to gender. Cohen-Kettenis and Pfafflin (2009, p.1) noted the American Psychiatric Association (2013) has approached gender difficulties from the viewpoint being *"a divergence between the assigned sex or ''the'' physical sex (assuming that ''physical sex'' is a one- dimensional construct) and ''the'' psychological sex(gender) per se signals a psychiatric disorder".* There has been a long-standing debate about whether Gender Identity Disorder should remain within the DSM as reported by

Winters (2005) and Meyer-Bahlburg (2010) due to the limited amount of evidence supporting its pathology and classification as a mental disorder.

Lev (2004) argued while the diagnosis of Gender Identity Disorder can be beneficial for professionals, it can also be used to stigmatise those who are considered to live outside the norms of acceptability socially. Cook (2004, p.44) added medical and psychological professionals use the term Gender Dysphoria due to an underlying assumption that the dysphoria *"causes the gender variant behaviour".* Hines and Sanger (2010), noted that this assumption continues to place medical practitioners within the role of 'expert' which contrasts with counselling psychologists' who have rejected this role and that of the medical model.

Despite classification in the above diagnostic manuals, there remains ambiguity regarding its aetiology (Di Ceglie, Freedman, McPherson, & Richardson, 2002). Nevertheless, a multi-faceted model including factors such as biological, psychological and social have been hypothesised (see Coates, Friedman, & Wolfe, 1991**;** Money, 1994; Zucker & Bradley, 1995; Di Ceglie, 1998). Bouman and Richards (2013, p.166) cited the ICD and DSM as comparable, with the former seeking to reconceptualise 'Gender Identity Disorder' to 'Gender Incongruence' and in-turn abandon: "*a psychopathological model of transgender identity in favor of a model that reflects current scientific evidence and best practice, responds better to the needs and rights of this vulnerable population, and is more supportive of the provision of accessible and high-quality health care services*".

It is worth noting within the medical field there again lies ambiguity in terminology regarding transition surgical procedures with variations including *gender affirmation surgery* (GAS) (Teich 2012), *gender reassignment surgery* (GRS), *genital*

reassignment surgery (GRS), *genital reconstruction surgery* (GRS), *genital surgery* (GS), and *sex reassignment surgery* (SRS) (Fenway Health, 2010). As with the term 'transgender' the above terms are recognised as umbrella terms encompassing a range of procedures which can include: ***Female-to-Male*** - hysterectomy-oophorectomy, salpingectomy, mastectomy, glansplasty, vaginectomy, urethral reconstruction, scrotoplasty, phalloplasty, penile reconstruction, penile (erection) prosthesis and testicular prostheses (Boedecker, 2011; Tonseth et al., 2010; Teich, 2012); ***Male-to-Female*** – Penectomy, Orchiectomy, Chondrolaryngoplasty, Breast Augmentation, FFS: Facial Feminization Surgery, Clitoroplast, Labiaplasty, Urethroplasty, Vaginoplasty (Boedecker, 2011; Teich, 2012; Hess, Neto, Panic, Rubben, & Senf, 2014) (See Appendix A for Glossary). Would the medical terminology, lack of clarity regarding aetiology and variations within it, be viewed by clinicians' as a barrier to working with transgender clients?

2.10.2 Therapeutic Model

Different therapeutic approaches and theoretical paradigms have been postulated over the years regarding best practice for working with people who identify as transgender. Shealy (2015, p.2) argued while there is an "*abundance of literature addressing best practices*", there is "*a dearth of literature on the specific mechanics and interventions that have been useful*" when working with transgender and gender non-conforming clients. His research cited a proportion of clinicians did not adapt their approach when working with cisgender or transgender clients, whereas others recognised adapting their approach but using cognitive behavioural therapy, creative visualisation, developmental theory, hypnosis, narrative therapy, person-centred and psychodynamic theory. In contrast, Fraser (2009,

p.127), argued: "*Issues that emerge in psychotherapy with transgender people are the same ones that emerge for anyone else, issues of self and self-in-relation, autonomy and connection, identity and intimacy*".

Bussey and Bandura (1999) stated several important theories have sought to explain gender development over the years, using biological, psychological and sociological paradigms, with each differing in essential aspects. Carroll and Gilroy (2002, p.233) argued it is essential for counsellors to recognise the role of traditional approaches and how they have "*pathologized individuals with nontraditional gender identities*". Califia (1997) reported three core theoretical paradigms within the debate regarding Gender Dysphoria. These include the psychoanalytic approach – based on the premise of innate bisexuality in humans with "*male-to-female transsexualism*" resulting from a "*failure of a boy to separate himself from his mother in early boyhood*" (Cook, 2004, p.46). However, the approach does not explain people who display gender variant behaviour who have not had such backgrounds and has "*little empirical evidence to support it*" (Bussey & Bandura, 1999, p.3).

The second paradigm related to Behaviourism, where gender identity is viewed as a result of the learning processes "*imprinting*" and "*conditioning*" (Califia, 1997, cited in Cook, 2004, p.47). However, familial and societal systems encountered throughout everyday life, weaken the argument. The last approach reported by Califia (1997) was the Cognitive Developmental Theory, which posited gender identity was related to the "*maturation of cognitive development*" (Califia, 1997, cited in Cook, 2004, p.48). In contrast, there is a wealth of research indicating there is not a relationship between a child's understanding of "*gender constancy and their preference for gender-linked activities …same-gender peers, or emulation of same-gender models* regardless of how

gender constancy is assessed *(Bussey & Bandura, 1984, 1992; Carter, 1987; Carter & Levy, 1988; Huston, 1983; Martin & Little, 1990)"* (Bussey & Bandura, 1999, p.4). All of these approaches have at times been viewed as "*credible*" (Cook, 2004; p.46).

It is also pertinent to mention the role of 'Queer theory' and in particular the idea of '*performativity*' of gender, as they both have had a significant impact within social sciences, and how people think about gender. Judith Butler is cited as the theorist who *"has done most to unpack the risks and limits of identity*" (Jagose, 1996, p.83), with an emphasis on how discourse can affect behaviour. Butler (1990, cited in Jagose, 1996, p.84) argues that "*there is no gender identity behind the expressions of gender*" and that "*identity is performativity constituted by the very "expressions" that are said to be its results*". Therefore, rather than gender being a role which is played and created by a person, it is performed on a daily basis, played out via systems of behaviours and actions that society agrees constitute the masculine and feminine. Thereby raising the question are those whose performance of gender does not fit social norms finding themselves in marginalised positions.

2.10.3 Therapeutic Approaches

Richards (2016, p.14) reported that "*trans people are no more likely than the general population to have any form of psychopathology (Cole, O'Boyle, Emory & Meyer III, 1997; Colizzi, Costa & Todarello, 2014; Haraldsen & Dahl, 2000; Hill, Rozanski, Carfagnini & Willoughby, 2005; Hoshiai et al, 2010; Kersting et al, 2003; Simon et al, 2011)*". However, Austin and Craig (2015, p.21) argued due to the difficulties the

transgender community face across the life-span including discriminations and victimisation, there are higher rates of "*suicide, anxiety and depression*".

Bittner (2016) added life stressors such as increased levels of distress of a psychological and physical nature, can lead them to seek out additional support, comparable to the rest of the population (Firth, 2015, cited in Richards, 2016, p.14). Austin and Craig (2015, p.21) stated in order to address these issues "*clinical interventions must be empirically supported and affirming, competently and sensitively attending to the effect of transphobic discrimination on the lives and experiences of transgender people*". They also recommended a "*transgender-affirming adaptation of a cognitive behavior therapy intervention (TA-CBT)"* (Austin & Craig, 2015, p.21). This view is also supported by Busa, Janssen and Laskshman (2018, p.27) who argued for an adaptation of the Cognitive-Behavioural Therapy model to ensure that treatment is "*efficacious and culturally sensitive*" for transgender youth.

Additional therapeutic approaches have included affirmation therapy, aversion therapy, conversion therapy, electroconvulsive therapy, hypnosis, medical interventions, psychoactive medications, reparative therapy, sensory deprivation, *"religious-based interventions***"** (Green, 2017, p.8) and *"other noxious treatments"* with the aim of seeking a *"cure"* (Israel & Tarver, 2001 p.18) were common-place and recommended (Denny, 2006). It was evidenced at the beginning of the literature review how the terminology relating to transgender has changed. A similar evolution can be seen in therapeutic approaches, with the most significant change in thinking relating to conversion therapy.

Affirmative therapy was borne from an awareness that "*sexual minorities benefit when the sexual stigma they experience is addressed in psychotherapy with interventions that reduce and counter internalized stigma and increase active coping*" (Glassgold et

al., 2009, p.1-2). Rock, Carlson and McGeorge (2010) reported that affirmative therapy promoted a favourable view of LGB identities. Embaye (2006) noted the positive tenets of affirmative therapy and posited they could be extrapolated to working with the transgender community.

Benson (2013, p.23) reported *"affirmative therapists possess an understanding of the stigmas that transgender clients live with and accept the person as they define themselves in terms of their gender and sex".* Glassgold et al. (2009, p.5) noted affirmative therapy supports client's identity development by providing a "*safe space where the different aspects of the evolving self can be acknowledged, explored, respected, and potentially rewoven into a more coherent sense of self that feels authentic to the client*". Sheerin (2009) added it is supportive of client-centred therapeutic approaches, as they recognise and value all gender identities and presentations as equal. The approach is also supported by the Association of Lesbian, Gay, Bisexual and Transgender Issues in Counselling (ALGBTIC), who stated affirmative therapy is a positive approach when working with transgender clients, as it recognises the negative impact transphobia can have along with irrational fears regarding the transgression of social gender 'norms' (ALGBTIC, 2009). Lev (2005, p.35) recognised this in her research and reported classification has remained controversial due to viewing those who *"violate societal norms"* within a psychiatric framework.

Conversion therapy is also known as *"reparative therapy, gay cure therapy and sexual orientation and gender change efforts*" (UKCP, 2018, para. 2) has been used since the early 1890s and was a common practice until recent decades (King, Semlyen, Killaspy, Nazareth, & Osborn, 2007). It is an approach based on the notion of identifying as LGBT is "*abnormal*" (Mallory, Brown, & Conron, 2018, p.1) and can be changed.

Glassgold et al., (2009, p.22) cite practitioners have also used aversion therapy which included practices such as "*inducing nausea, vomiting, or paralysis; providing electric shocks, covert sensitization, shame aversion, systematic desensitization, orgasmic reconditioning, and satiation therapy". (Beckstead & Morrow, 2004; S. James, 1978; Katz, 1995; Langevin, 1983; LeVay, 1996; Murphy*, 1992, 1997)". Thankfully, due to its unethical and harmful nature, all major counselling and psychotherapy professional bodies including the NHS, united in condemning and ending its practice in 2018 via a Memorandum of Understanding (MoU). Within the USA as of January 2018, nine states, District of Columbia and 32 localities have banned the use of conversion therapy on youth (Mallory et al., 2018, p.4)

Fraser (2009, p.129) advocated for the use a Jungian therapeutic perspective when working with transgender clients, as it focuses on the "*fostering individuation, "being who the person is meant to be (Wheelwright, 1982)".* She advocated for this perspective as individuation can be a challenge for transgender people, due to cultural and societal norms and the expectations of others, with the focus remaining on the client's development of who they uniquely are in the world. Additional affirmative therapeutic approaches are beginning to emerge and gain recognition which includes art therapy (See Addison, 2003; Beaumont, 2012; Embaye, 2006; Newman, 2002; Nuttbrock et al., 2002; Pelton-Sweet & Sherry, 2008; Raj, 2002; Schnebelt, 2015) as a means of exploring clients narratives for identity development, *"processing decisions related to transitioning, and deconstructing experiences of internalized transphobia to find self-acceptance"* (Schnebelt, 2015, p.46).

Further considerations are evident in family therapy, whereby traditional models of binary relationships have been the dominant approach (Hare-Mustin, 1987). Edwards,

Goodwin and Neumann (2018, p.2) stated there is "*little to no evidence that family therapists as a whole are prepared to effectively serve transgender clients*" at present. Blumer, Ansara, & Watson (2013) and Chapman and Caldwell (2012) noted there remains a dearth of literature and research on relationships between transgender persons and their partners. Sharstrom (2015, p.47) added there are a limited number of studies which have considered the *"experiences of transgender couples both in and out of the therapy room*" and there is inadequate training for family therapists to address this.

Coolhart and Bernal (2007, p.36) reported "*the transgender population have been largely neglected in the family therapy field"* and often included in matters relating to the LGB community, without addressing or differentiating transgender experiences. Edwards et al., (2018, p.2) added the American Association for Marriage and Family Therapy have not developed any standards for family therapists and have been "*slow to acknowledge the diversity of gender identity*". Despite the lack of formal guidance, there are some published articles authored by family therapists providing clinical information (See Coolhart, Provancher, Hanger, & Wang, 2008; Coolhart & Shipman 2017; DeBord, Fischer, Bieschke, & Perez, 2017; Lev 2004). As a consequence, family therapists are left with limited direction and support, which they may perceive as a barrier to working with transgender clients/families.

2.10.4 Therapeutic Experiences

Research has shown transgender clients have reported both positive and negative experiences when seeking support from mental health clinicians, with negative experiences including breaches in confidentiality, lack of knowledge from clinicians and

maltreatment (See research by Grant et al., 2011; Heinz & MacFarlane, 2013; MacFarlane, 2015; Pitts, Couch, Croy, Mitchell, & Mulcare, 2009; Sheerin, 2009). Barker (2017, p.15) reported that in terms of gender, relationships, sexuality and diversity, research suggests clients will have had therapeutic experiences which involved them being "*explicitly or implicitly pathologised by practitioners*".

The Transgender Mental Health and Wellbeing Ireland (2013) conducted research exploring the mental health and well-being of transgender people. The study found that 40% of the 164 participants were discouraged from seeking support and counselling due to positive and negative prior experiences. Furthermore, the study found when accessing services, professionals had a *"lack of knowledge and awareness of the specific health care issues*" (McNeil, Bailey, Ellis, & Regan, 2013, p.11) about their transgender clients**.**

Research by Rachlin (2002) found a proportion of therapists assumed transgender clients were seeking therapy due to distress related to their gender identity, when, in fact, it could be a myriad of additional reasons besides their gender identity – this approach is reinforced through the medical model literature which is diagnostic focused. Fraser (2009, p.129), argued a therapist's approach, should be open-minded, no pre-conceived ideas, and a working collaboratively to search for the "*client's truth*". However**,** Benson (2013, p.87) did report some of the reasons could be attributed to a persons' gender identity, including the *"guilt and shame",* of having to hide and in effect live a lie. Also, some sought therapy due to decreasing mental health, which was correctly attributed by clinicians' as about their gender identity although not recognised by them at the time. It is worth considering whether the interplay between the medical (e.g. psychiatrists) and social model (e.g. psychologists, counsellors, psychotherapists) are an influencing factor on whether the client feels the therapeutic experience is positive or negative?

Furthermore, does a clinician's clinical training have a bearing on their approach to working with gender dysphoria and thus attitudes towards treatment?

Another consideration within the therapeutic model when working with transgender clients has been highlighted by Carroll and Gilroy (2002), Nelson (2016), Smith (2016), and Williams and Freeman (2007, p.101) who reported transgender people experience a degree of distrust regarding mental health professionals, as they have been perceived as gatekeepers to transitioning. Williams (2015, para.1) defines gatekeepers as *"a medical professional"* who *"restricts access to an intervention on paternalistic grounds".* Sheerin (2009), noted the role of mental health professionals had been viewed as controversial as it can impede the therapeutic relationship, with particular emphasis on the development of trust. Waszkiewicz (2006, p.17) reported while professionals adhere to the WPATH guidelines and the diagnostic criteria of Gender Identity Disorder; they are also working within confines of *"psycho-medical gate-keeping"*. Budge (2015) questioned if psychotherapists are a 'gatekeeper', can transgender clients' engagement in the therapeutic process be regarded as voluntary and have they truly given informed consent when it is a required component of transitioning?

A symposium report produced by the National Health Service (NHS England, 2015, p.9) noted the need to remove 'gatekeepers' from Gender Identity services and reflection on client accounts, who reported experiencing *"manipulative gatekeeping by the clinics that compromises genuine therapeutic alliances between clinicians and patients".* They also recognised General Practitioners (GP's) are 'gatekeepers' and aligned the need for this role with the Hippocratic Oath of 'do no harm.' Also, the report stated transgender people are *"forced into a set narrative by a standards of care model"* (NHS England, 2015, p.12). Bockting et al., (2004, p.277) reported the role of

'gatekeepers' by professionals including Mental Health could be perceived as *"unnecessarily pathologising"* the transgender community. Bensons' (2013) research illustrated the frustration felt, due to the need for mental health professionals to legitimise their experiences and gender identity. Lev (2004) noted due to the perception and distrust clients may not be as open and honest about difficulties they are encountering as their primary focus is on presenting a healthy sense of self to the therapist. Lev (2004) added that many had viewed the therapeutic goal to be obtaining the approval letter to progress with the medical aspect of transitioning. Therefore, it is viewed as a *"hoop"* (Bockting, Knudson, & Goldberg, 2006, p.19) to jump through to reach the desired goal. If clinicians perceive a clients' engagement is for 'secondary gains', does this affect the therapeutic relationship and the service delivered, thus presenting a further barrier?

Sheerin's' (2009) research exploring '*Transgender individuals' experiences in therapy and perception of the treatment experience',* highlighted many positive attributes therapists possessed/conveyed which were regarded as enabling factors for a positive therapeutic experience. These qualities included understanding, being sympathetic, gentle, "*compassion, openness, acceptance, interest in learning about or previous knowledge of trans issues and help in finding and accessing resources*" (Sheerin, 2009, p.44). Concerning barriers to successful therapeutic outcomes, factors including therapists not supporting client's decisions to transition, clients attending therapy sessions as their true-self and discriminatory behaviour, resulted in "*lower treatment satisfaction and lower ratings of working alliance*" (Sheerin, 2009, p.48).

3 Training

Barker (2017, p.7) reported "*Gender, sexuality, and relationships are all given a high level of importance in 21st-century western culture*". She added it is vital clinicians "*have a good working knowledge*" of these, and how they can vary, as they may be of significance to clients (Barker, 2017, p.7). Barker (2017, p.16) also noted that is not always included within therapeutic training, with the assumption:

"*clients will be cisgender, heterosexual, monogamous men and women and promote understandings of psychological healthiness that involve remaining in the gender assumed at birth, seeking monogamous romantic coupledom, and engaging in penis-in-vagina intercourse".*

A lack of knowledge about these aspects could be viewed as a barrier to effective clinical work, which may further be compounded by the limited inclusion within core clinical training and continuing professional development opportunities. MacFarlane (2015, p.11) cited the lack of *"counsellor competency in working with trans populations"* along with financial limitations as a significant barrier preventing access to counselling services.

Raj (2002) reported a vast disparity between clinicians training, competence and experience in working effectively with transgender clients; this was also recognised by Benson (2013), who noted a lack of training for mental health clinicians which addresses sexuality, gender and gender identity. Lev (2004) noted that existing training frequently focuses on the medical model/diagnostic criteria aspect. This view is also supported by Bess and Stabb (2009, p.264), who found transgender clients thought clinicians still required additional training. However, some reported "*supportive and affirming relationships with their therapists*".

Lee et al., (2018) reported at present the training curriculum for healthcare professionals do not include information about the health-care needs of transgender persons, and there are limited guidance/guidelines for reference. It is important to recognise that WPATH Standards of Care-7, do recommend a set of minimum credentials clinicians should have when working with adults who present with gender dysphoria. These include a master's degree or equivalent in a clinical behavioural science field; training and competence in the use of the Diagnostic Statistical Manual of Mental Disorders (DSM) and/or International Classification of Diseases (ICD) for diagnostic purpose; knowledge of gender non-conforming identities and expression through supervised training and continuing professional development on the treatment of Gender Identity (Carlozzi, 2017). However, these are only a recommended set of credentials and not a mandatory pre-requisite to working with transgender and gender non-conforming clients and are inclined towards the medical model.

Schnebelt (2015, p.1) conducted research exploring therapeutic considerations when working with people who identify as transgender. He found that *"mental health practitioners are not properly trained ... in the specific concerns and challenges of the transgender population to provide appropriate standards of care".* Lev (2004, cited by Glavinic, 2010, para.2) noted: *"the majority of clinicians, including social workers, counselors, psychologists, psychiatrists, and physicians, have not received training on the treatment of sex and gender identity or issues involving gender dysphoria and transgenderism".* Glavinic (2010, para.3) added lack of training for clinicians' is troubling as *"virtually all trans patients have to interact with multiple psychologists and physicians".*

The UK government released a publication in 2016 acknowledging *"the NHS is letting down trans people, with too much evidence of an approach that can be said to be discriminatory and in breach of the Equality Act"* (House of Commons, 2016, p.35). Bradley (2015, cited in House of Commons, 2016, p.35) further added there is a *"lack of understanding and lack of cultural competency around trans issues"* within the NHS. Before the House of Commons publication, Lev (2004, p.21) reported *"many clinicians have not had basic training in sexual and gender identity development"* which is a fundamental part of life-span development. Also, she added *"Transgendered studies need to become part of all counselor training and in-service programmes. Clinicians need to become sensitised to the assessment, treatment, and proper referral for gender-variant people and their families"* (Lev, 2004, p.21).

Hanssmann, Morrison and Russian (2008) evaluated clinical and cultural competence training programmes administered by non-profit health agencies in Seattle, USA. They found that adequate training was rarely integrated into health care professionals training regarding gender identity, but things were beginning to change for some health care staff/providers. It is anticipated that an increase in training will reduce *"barriers to services"* (Hanssmann et al., 2008, *p.22*). It is recognised that the evaluation was on a small-scale. However, other research has also supported their findings including MacFarlane (2015) who reported within Canadian and US medical training programmes only seven hours are dedicated to content relating to LGBT populations. Obedian-Maliver et al., (2011) added a high proportion of Canadian teaching did not include any LGBT content.

Within the UK, Merrifield (2016) reported a survey of 1,200 nurses with the Royal College of Nursing whereby nearly 80% of nurses had not received any education or

training about working with transgender clients', yet three-quarters of them had worked with transgender patients. It is recognised that a lack of adequate or any provision of training applies across the health care system and other professions. Davidge-Pitts, Nippoldt, Danoff, Radziejewski and Natt (2017) reported on 382 practising Endocrinologist clinicians surveyed, 80.6% had never received any training regarding the care of transgender patients despite working with the client group. NHS England held a symposium in 2015 where it was reported that there is a *"need to train more professionals with appropriate skills"* (Hakin, 2015, cited in NHS England, 2015, p.6). Dean (2015, cited in NHS England, 2015, p.7) added from his own experience there was a definitive *"variability in attitude and approach of clinical, managerial and support staff"* which ranged from *"accepting, empathetic and supportive, to the unhelpful, dismissive and hostile"* from healthcare staff. Case and Meier (2014, p.62) reported a lack of training within the educational system could also leave professionals feelings *"unprepared to become allies to this disenfranchised community and attend to their needs"*.

On a positive note, MacFarlane (2015, p.13) reported ensuring health-care is at the minimum respectful would not "*require extensive training*". Also, he cited research by Pitts et al., (2009), who noted qualities valued by healthcare practitioners included empathy, compassion, a non-judgemental approach and respect – all of which align with Counselling Psychology core principles, can have a significant effect on patients' experiences of treatment.

4 Beliefs and therapeutic needs

A lack of training has the potential to result in a lack of awareness regarding the therapeutic needs of transgender clients, Devaney (2005) argued: "*transgender people face unique challenges based solely on their gender identity*". Seil (2004, cited in Devaney, 2005, p.5) reported a "*large number of transgender people have other mental health diagnoses*", adding that his research found 37.2% had secondary diagnoses in addition to substance abuse and GID. Devaney (2005) hypothesised isolation and guilt might be an explanation for the findings. Embaye (2006, p.62) cited his own experiences as a client and clinicians imparting their beliefs regarding his transition, noting one therapist commented he was "*too pretty to be a man" and a colleague stating he was "too old to transition"* (Embaye, 2006, p.61).

Nuttbrock, Rosenblum and Blumstein (2002) stated there are many ways in which clinicians can work effectively with transgender persons of all ages. They cited this included working in a manner which positively supports Gender Identity, as this is key to negating some associated mental health difficulties. Schaefer and Wheeler (2004, p.118) researched the guilt experienced by transgender persons and found "*Guilt is often the motivating factor that dictates how gender-distressed persons interpret, manage, and live their lives"*. They added it is vital that professionals have an awareness of the impact of guilt on Gender Identity Disorder and are willing to address this during therapy.

Seidl (2006, cited in MacFarlane, 2015) noted additional factors which transgender persons experience causing distress, which can stem from a lack of acceptance and societal experiences.

5 Transition and Treatment

Sheerin (2009) argued the importance of mental health clinicians not only being culturally competent but also having knowledge of effective treatment, strategies and oppressive factors. Barker (2017, p.15) provided the example how the DSM-5 has "*categorically stated that asexuality is not pathological [with] many sex therapists remain[ing] unaware of this and assum[ing] that not experiencing sexual attraction is a disorder to be treated*".

As noted earlier in the chapter, there has been an unprecedented increase in demand for gender services. Subsequently, there have been difficulties meeting demand, due to the lack of clinicians within specialised gender services, this is further compounded by *"general practitioners feel[ing] ill equipped to deal with questions about gender*" (BMJ, 2018, para.4). Mueller et al., (2017, p.1155) noted there is an increasing role for mental health clinicians in the "*assessment and treatment of gender dysphoria in transgender individuals*". Due to this increasing need, it is vital that clinicians are versed in what 'transition' means and the implications. How can they help clients determine what is in their short, medium- and long-term best interests when they do not necessarily know, nor have the research to appraise?

5.1 Transition

As evidenced throughout this Chapter, there are limited unified definitions and understandings concerning terms, language, approaches, training and standards in respect of working with transgender clients. The same difficulties arise about 'transitioning' and the "*diversity embraced by the term*" (Livingstone, n.d, p.4), nevertheless it is another crucial element clinicians' need to understand and be competent working with. Meadow

(2011) highlighted the correlation between transitioning and the medical model for those seeking medical transition and the need to navigate a complicated process, which could be an enabling or barrier factor for some (See Brown, 1990; Bryant, 2011; Dewey, 2008; Rose, 2007; Tone, 2012).

Lee et al., (2018, p.2) stated that transition-related healthcare could aid in improving persons "*physical and mental health as well as quality of life".* Joseph, Cliffe, Hillyard and Majeed (2017, p.11) noted that the process of transition could involve input from a range of discipline including "*primary care, psychology, psychiatry, social services, endocrinology, and surgery, according to the wishes of an individual patient".* Tollinche et al., (2018, p.2) added that "*transition is highly variable*" and can be viewed as a continuum; with some choosing to not transition at all, socially transitioning, through the use of techniques such as binding and tucking and adjustment in mannerisms and dress.

Within a medical framework, Hird (2002, p.578) reported that a person's journey of transition could be "*either pretransition/operative, transitioning/in the process of hormonal and surgical sex-reassignment, or posttransition/operative (Bolin, 1994; Prosser, 1998)*". Quinn et al., (2017, p.1-2) added that gender affirmation treatment could "*involve administration of cross-sex hormone therapy (HT) to achieve desired masculinisation or feminisation, and/or surgical change of the genitalia and other sex characteristics".* Rachlin (2009) viewed the transition as encompassing both aspects from changes in pronoun to surgery. De Haan, Santos, Arayasirkul, and Raymond (2015, p.313) argued there is a barrier for transgender patients accessing healthcare due to inconsistencies in providers, and advocated for more "*culturally-competent, affordable, and accessible providers*". In relation to surgical transition, Dhejne et al., (2011, p.1) reported there is a "*dearth of long term, follow-up studies*", and noted there needs to be

an improvement in the psychiatric and somatic after care available. They added this was important as "*even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual person*" (Dhejne et al., 2011, p.7). In contrast, Frank (2018, para. 1) carried out a systematic review on studies relating to transition and well-being and found transgender adults who transition with the aid of medical treatment reported improvements in their "*quality of life, self-esteem, confidence and relationship satisfaction and decreased anxiety, depression, suicidality and substance use"* (See What We Know Report, Cornell University, 2018).

Tollinche et al., (2018, p.10) concluded it is imperative for clinicians to have "*appropriate training*" for working with transgender clients, which should commence "*early in the education of health care providers*" and referred to standards and guidelines to further support clinical work (See WPATH 2012; Deutsch 2016; Hembree et al., 2017). The WPATH standards are updated regularly and are aimed at setting the "g*lobal standards of care*" (Jospeh et al., 2017, p.11), recent revisions have seen the requirement of a period of Real-life Experience (RLE) no longer being deemed essential (WPATH, 2012). Prior to the change, progression to surgical transitional procedures from the RLE was based on a clinician's recommendation, which could cause a dichotomy within the therapeutic relationship due to the "*supportive position most caring professionals adopt*" (Barker & Wylie, 2008, p.121).

Shadianloo and Pleak (2019) also advocated for therapists to have a good knowledge of the role of transition across the life-span, with an understanding of the complexities, irreversibility of aspects and the familial dynamics this can create. Lev (2000), noted there is often a dependency on professionals for recognition in order to progress with a

transition, e.g. accessing hormones. She added psychotherapy could aid clients in transitioning from "*a false life to the awakening to an authentic self*" and aid in practical aspects including "*legal name changes, transitioning on the job, or coming out to children*" (Lev, 2000, p.12). As a result of the latter aspects, it is essential that clinicians have sufficient knowledge of these processes and situations to support clients successfully.

5.2 Standards of care

The World Professional Association for Transgender Health (WPATH) began publishing Standards of Care (SOC) in 1979 and 1980, 1981, 1990, 1998, 2001 and 2011 forthwith; previously known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA) after one of the first physicians to work with "*gender dysphoric persons*" (Devor, 2019, para. 1) . The SOC provides ethical and best practice guidelines for people working with the transgender community; however as noted by the publication dates, they may not always reflect the most current approaches and modalities.

The WPATH guidelines have historically encouraged professionals to focus on the 'body' as they determined someone's' *"candidacy for undergoing bodily alterations is based on their psychological well-being"* (Benson, 2013, p.18). Green (1999, cited in Bellinger vs Bellinger, 2001, para.32), a leading specialist, has also noted: *"severe gender dysphoria cannot be alleviated by any conventional psychiatric treatment, whether it be psychoanalytic therapy, eclectic psychiatric treatment, aversion treatment, or by any standard psychiatric drugs".* Seil (2004, p.103) argued a range of clinicians from different disciplines is required when working with GID, which includes "*professionals*

from general medicine, endocrinology, surgery, psychiatry, psychology, and social work".

The WPATH guidelines are designed to instruct professionals on *"psychiatric, psychological, medical and surgical"* aspects (Goldberg, 2009, p.11). Bockting and Goldberg (2006) stated that while most clinicians follow the HBIGDA standards of care, it is not a legal requirement or requisite for working with transgender clients. As a result, the treatment offered and received across the United States and the world is not a unified or standardised pathway.

Coleman et al., (2012) acknowledged an increase in research in the last two decades, which has led to the development of a more trans-affirmative practice across a range of disciplines. In response to the increase in research and subsequent literature, a rise in the availability of continuing professional development courses, therapeutic tools and guidelines designed to aid therapists to work effectively with transgender clients. Therapeutic tools have included the Genderbread person (Killerman, 2012) and the Gender Unicorn (Pan & Moore, 2016), both of which are infographics designed to aid in the understanding of gender identity, expression, biological sex and orientation (See Appendix E & F). Also, there is a set of guidelines written by the American Psychological Association (2015, p.832) aimed at assisting psychologists in providing "*culturally competent, developmentally appropriate, and trans-affirmative psychological practice*". Furthermore, there is a wealth of documents outlining the appropriate language to use in the therapy room (See documents by GLAAD, n.d; ALGBTIC, 2009; Trans Media Watch 2010-2015). However, Barrow (2014) argued that even for experienced clinicians, the language is diverse, complex, multi-faceted and continually changing, with her often being reminded by clients that terms used are outdated and how ensuring the language

used is ‘current’ is of vital importance. Are the changes in language, causing concern of getting it wrong or offending, thereby preventing therapists from working with transgender clients?

Clarke, Ellis, Peel and Riggs, (2010, p.138) stated mental health services are “*often ill-equipped to address the mental health needs of LGBTQ people”* due to a history of pathologising gender and sexuality. Nuttbrock, Rosenblum and Blumenstein (2002), argued the pathologisation has continued with transgender identities being undermined through the value society places on the gender binary. Richards (2016, p.20) noted that “*trans people have historically been ill-served by health professionals in relation to their gender and sexuality*”. Benson (2013, p.17), added that mental health research has traditionally viewed *“transgender people through the narrow lens of gender identity disorder*” in conjunction with a lack of training, the resultant effect can be clinical misunderstandings and insensitive care (Coolhart & Bernal, 2007). As a result, understanding regarding treatment and services considerations remain an emerging field and in need of direction.

6 Risk

A final consideration pertains to research suggesting the transgender community has a higher prevalence rate of self-harm and suicide than the general population and its effect on clinical practice. Within LGBT youth, research indicates a higher risk of suicide and self-harm compared to heterosexual or cisgender counterparts (McDermott, Hughes, & Rawlings, 2016). Research also suggests there is a disproportionately higher risk of abuse, hate-crime, suicide and lower economic status within the transgender community than

their cisgender counterparts (See Calton, Cattaneo, & Gebhard, 2016; Crissman, Berger, Graham, & Dalton, 2016).

In respect of self-harm, it is recognised as a complex subject due to variations in aetiology, function and presentation. Turp (2003, p.9) recognised the complexity and stated its various forms ranging from the *"highly dramatic to the virtually invisible".* Although the terminology surrounding self-harm is varied, it is defined as acts of self-directed violence of a repetitious nature including; self-cutting, self-scalding, and overdosing (Turp, 2003) and are *'self-initiated'* (Van Orden et al., 2010). Self-harm is recognised by many as being on a continuum (Connors 1996; Croyle & Waltz, 2007; Stanley, Winchel, Molcho, Simeon, & Stanley, 1992; Turp, 2003), and include behaviours including; risk-taking behaviours, drug use, medication misuse, burning self, swallowing objects, hitting yourself, mutilation of genitals, pulling out of body hair and other self-attacking behaviours. Connors (1996, p.198) added it is essential to place the self-harm within the context of *"intent, the psychological state accompanying the act, and how the act affects not just the body but the self as well"*. In relation to the transgender community, additional self-harm behaviours have been observed to include utilising chest binders as a replacement for cutting (Alderton, 2016), chem-sex, self-castration and genital mutilation.

There is also a recognition that a proportion of people who attempt suicide have a history of self-harm behaviours, irrespective of intent (O'Connor & Sheehy, 2000; O'Connor, Sheehy, & O'Connor, 1999). Klonsky, May and Saffer (2016) reported: *"Suicidal behaviour is a leading cause of death and disability worldwide"*. World Health Organisation (WHO, 2014), reported approximately 6000 people in the UK and 804,000

people worldwide die through suicide - one every forty seconds with a prediction by 2020, a person will die by suicide every twenty seconds (WHO, n.d).

Research about vulnerabilities to suicide for people who identify as LGBT posits they are at higher risk than their heterosexual peers (Clements-Nolle, Marx, & Katz, 2006; Hatzenbuehler, 2011; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Langhinrichsen-Rohling, Lamis, & Malone, 2010**;** Mathy, 2002). Pollock (2015, p.4) stated that research undertaken in the UK has confirmed that suicide is a "*huge issue within trans communities*". Research carried out by PACE and Risk and Resilience Explored (RaRE) published in 2015, reported transgender individuals to have *"significantly higher rates of both lifetime and previous year suicide attempts and ideation… [and] significantly higher rates of lifetime and previous year self-harm ideation and experiences"* (Nodin, Peel, Tyler, & Rivers, 2015; p.47).

A study carried out in 2007, reported 34.4% of adults who identified as transgender had attempted suicide at least once and 14% more than once (Whittle, Turner, Al-Alami, 2007). Haas, Eliason, Mays, Mathy, Cochran, D'Augellu et al., (2011, p.10) noted that despite the known elevated risk of suicidal ideation/attempts within the LGBT population, it had been given *"relatively little attention"*. Haas et al., (2011) research were initiated following a conference between the American Foundation for Suicide Prevention, in partnership with the Suicide Prevention Resource Center and the Gay and Lesbian Medical Association, which acknowledged the vast gaps within the research literature and subsequent practice.

The Institute of Medicine of the National Academies (2011, p.4) reported the LGBT community has *"unique health experiences and needs"* and we need to understand these more (Also see Weining & Lehmiller, 2016). In 2016, the UK government issued

the ‘Gender Recognition Act’ review and announced the plan for a transgender equality’ paper and recognised that in 2013, *“trans young people (under 26) in England were nearly twice as likely (48%) to have attempted suicide in their life compared to non-transgender peers (26%). Trans young people were nearly three times more likely to have self-harmed in the preceding 12 months (59%) than their non-transgender peers in the study (22%)”* (Government Equalities Office, 2016, para. 25-26**).**

7 Conclusion

Throughout the literature review, several gaps were highlighted from limited inclusivity within clinical training programmes, difficulties with language, cultural considerations and a lack of appropriately trained clinicians to effectively work with transgender clients. Richards (2016, p.4) posed the question due to the complexity surrounding the subject “*Where then is the counselling psychologist with a trans client to turn for information on trans experience which is free(er) from such theoretical (and so methodological) bias?”*

It also became apparent that due to the aforementioned gaps and limitations, an unforeseen vicious cycle has been created. For example, Lee et al., (2018) reported that participants of their research found a lack of clinicians and services able to diagnose Gender Identity Disorder, which impacted their ability to transition medically. Dewey and Gesbeck (2017), noted the process of diagnosis, can reveal clinicians cultural views regarding gender and mental health, which can be entrenched within the medical model of diagnostic categories. Brown (1995, cited in Dewy & Gesbeck, 2017, p.39) is reported as stating that the process of diagnosis is “*a language of social control*”; thus, potentially creating further barriers. It is important to note that there is also a cultural shift in motion,

aimed at addressing these barriers, this is particularly evident with the changes to the DSM-5 and ICD-10. However, Wakefield (2013) noted that despite the changes, the diagnostic criteria are still comparable.

In addition, several examples have been cited whereby clinicians are reported as providing a treatment which could result in a negative experience for the client and potentially working outside of competencies due to a lack of training (See Von Vogelsang, Milton, Ericsson, & Stromberg, 2016). Brown (2017) reported that due to the crucial role of creating a supportive therapeutic relationship, it is paramount the attitudes of healthcare professionals are investigated. Von Vogelsang et al., (2016) reported patients' experiences of healthcare professionals during medical transitional procedures. They noted that when the patients felt their integrity was being respected and preserved and the clinicians acted professionally, trust and confidence was more natural to establish. However, they reported a variation in level in expertise and knowledge among clinicians which led to patients feeling exploited and vulnerable at times. Joseph et al., (2017), added that further research is vital into the needs of transgender clients for non-specialists.

Johnson, Shipherd and Walton (2016, p.69) stated "*psychologists are integral to the care of transgender individuals*", in relation to the treatment of the gender dysphoria and other comorbid conditions. This again emphasises the importance of inclusivity within core clinical training. Nevertheless, despite there being a deficiency of formal training provision at present, there is a wealth of Continuing Professional Development opportunities for clinicians. These opportunities, along with the recognition that "*therapists are going to make mistakes*" (Swift, n.d, cited in Jarrett, 2017, para.3), but the ability to repair them creates the enabler or barrier to working with transgender clients.

Fraser (2009, p.127) noted that clinicians are beginning to respond more effectively to the lived experience of transgender people, and "*fitting the theory to the people and not the other way around*". It is hoped this research will aid in the continuation of the shift and further reduce the barriers clinicians experience when working with transgender clients.

In conclusion throughout the literature review, the difficulties faced by both practitioners, researchers and the transgender community have been highlighted across a range of topics, along with indicating gaps in the research. Marshall et al, (2017, p.2) stated that there remains "*limited information about the scope of research focusing on trans individuals and communities*". Therefore the rationale for this research is to contribute to the body of literature aimed at increasing the positive therapeutic experiences of the transgender community, by exploring what therapists perceive as the enablers and barriers to working with transgender clients.

Chapter 3 - Methodology

3.1 Introduction

This chapter will outline the methodological framework for the Thematic Analysis approach and method. The Chapter is divided into sections, where the research design including participant recruitment, inclusion and exclusion criteria, interview and transcription process and ethical considerations are discussed. It also includes a discussion of why Thematic Analysis was deemed the most appropriate method and the implications of the research data having been previously analysed.

It is the objective of this research to explore what therapists perceive are the enablers and barriers to working with transgender clients, through a qualitative exploration of therapists' experiences. However, it is important to note that it is outside the bounds of this research to explore the role of all professionals working with transgender clients or focus solely on the perspectives of Counselling Psychologists. Nevertheless, this research does seek to explore those working therapeutically with the transgender community, e.g. psychologists (counselling, clinical, and forensic), psychiatrists, counsellors and psychotherapists, with consideration on the impact for practising Counselling Psychologists. To ensure clarity, throughout the research the terms 'clinician' and 'therapist' are used as the descriptor for the person delivering the therapeutic interventions irrespective of clinical background and 'client' or 'patient'' for the recipient of the intervention.

As this was the second time the data has been analysed, it does influence the subjective judgements made by the researcher. Gross (2013) noted subjective judgements are an inevitable process within qualitative research, Loewenthal (2007) argued that

rather than avoiding subjectivity, it needs to be explained and used productively, through the transparency of decisions made, thereby enabling the reader to evaluate the research process. There were several advantages to the data set having previously been analysed; this included the interview data already transcribed verbatim providing the researcher with an in-depth knowledge of the content. A disadvantage is the in-depth knowledge of the research data in the context of the previous research design. Therefore the researcher needed to be mindful of not reverting to the previous research focus.

Originally Foucauldian Discourse Analysis (FDA) was selected as an appropriate methodological approach, because of its focus on the mechanics of language and how these produce dominant discourses which have an effect on truth, power and knowledge (Mills, 2004). However, recruitment challenges meant that insufficient data was collected to support a rigorous Foucauldian Discourse Analysis. Moreover, although rich data was elicited from therapists, it became clear that the extent of unknown and little understood factors influencing their confidence to work with transgender clients needed more exploration before a full Foucauldian Discourse Analysis would be feasible. Following a revision of the research questions and focusing on the extent of unknowns, an exploratory qualitative study became more appropriate. The revised methodology and methods are discussed in this chapter, including the selected new analytic approach (Thematic Analysis – Braun and Clarke, 2006). The data was re-analysed entirely using the new findings, and resultant discussions are presented in Chapters 4 and 5, with supplementary evidence of the analytic decision trail throughout.

3.2 Research Design

3.2.1 Theoretical Framework

Throughout this research, a Social Constructionism paradigm was embraced, as it acknowledges the multiple realities which exist and emphasises individual experiences (Braun & Clarke, 2006). Furthermore, it is rooted in phenomenology which is focused on the experiences of people and how those experiences shape them (Smith, Flowers & Larkin, 2009). This theoretical framework was deemed appropriate as it is aimed at increasing the understanding of human experiences within their world-view (Cohen & Manion, 1994) and reflection on those experiences (Honebein, 1996); this was deemed pertinent when exploring a therapist's own clinical experiences, which are a unique and subjective experience (Berger & Luckmann, 1991). Berger and Luckmann (1991) added that they are concerned with the construction of knowledge, its emergence and subsequent significance for society.

Additionally, Allen (1994) noted that Social Constructionism plays an active role in the shaping and congruence of practitioners' values within clinical work, while acknowledging client's difficulties and advocating for collaborative working to address these. She added that although the constructivist paradigm is congruent with clinical values within social work, it is also challenging them to re-examine their values and priorities.

Schneider, Gruman and Coutts (2005) posited gender as a social construct, influenced by sociocultural experiences throughout a persons' life-span/development. Brickell (2006) argued disparagers of psychiatric and biological theories of gender have sought to conflate the term and reduce it to a notion of learned behaviour. Cook (2004, p.52) argued Essentialism posits at its most basic level that *"men and woman are 'made that way'"*.

This is a contrast to social constructionism due to the distinction between "*biological sex and social gender*" (Stone, 2004, p.139). Brescoll, Uhlmann and Newman (2013, p.4) argued that psychological essentialism "*implies biological causation*" even when there is no possible biological explanation (Bem, 1993; Haslam & Whelan, 2008).

3.2.2 A Qualitative Approach

A qualitative approach was utilised, as the research involved empirical work with the collection of data through interviews which can *"concur, refute or contest theories which in turn allows for understanding and clarification for different observations*" (May, 1997 cited in Conroy 2010, p.16). In addition, the use of qualitative methodologies aligns with the underpinnings of Counselling Psychology in reference to its humanistic and phenomenological philosophy (McLeod, 2011).

Harper and Thompson (2011, p.5) noted qualitative approaches allow for an increase in "*understanding of experiences and processes*", and enables a researcher to understand meanings, experience, ideas, beliefs and values of the participants within the study (Wisker, 2007). In addition, qualitative research involves an inductive process, where data is collected in relation to a specific area of interest, allowing the researcher to posit theories and concepts.

Roller and Lavrakas (2015) reported ten unique attributes to qualitative research, and added within them are three dominant qualities; the importance of context, meaning and the participant-researcher relationship. Barney et al., (n.d) noted the approach is holistic and based on understanding world-views and not a single reality, as perceptions vary and alter over time. The research design supported this as it was inductive and focused on the

real-world experiences of clinicians, which allowed their narrative to unfold naturally. In addition, the use of semi-structured interviews aided in reducing the risk of not recognising and pursuing "*new paths of discovery as they emerge[d]"* (Spalding University Library, 2019, para.2).

Rossman and Rallis (1998, p.29) stated "*there are few truths that constitute universal knowledge; rather, there are multiple perspectives about the world"*, this resonated with the current research as the aim was to explore therapists' experiences of working with transgender clients, which would inevitably vary between participants. In addition, Merriam (1998, p.1) stated qualitative research affords the opportunity of "*the greatest promise of making significant contributions to the knowledge base and practice of education,*" because it is "*focused on discovery, insight, and understanding from the perspective of those being studied*". It is the aim that this research will aid in raising the awareness of the barriers clinicians experience when working with transgender clients and how to address these. As a result, a qualitative research approach was deemed the most appropriate for this research.

The research method utilised was a Thematic Analysis, also known as theme-analysis (Meier, Boivin, & Meier, 2006). It was used within the Social Constructionist framework outlined above, which seeks to understand "*experiences and meanings of the participant in relation to a boarder social context*" (Braun & Clarke, 2006, p.9).

Fertuck (2007) stated that Thematic Analysis was developed as a means of interpreting textual data in a rigorous and meticulous method, which allows for themes to emerge. Gross (2013, p.25) noted that with "*few exceptions the method is applied to empirical information gained from interviewing research participants transposed to interview transcripts (Attride-Stirling, 2001; Boyatzis, 1998; Braun & Clarke, 2006;*

Frith & Gleeson, 2004; Joffe, 2012; McLeod, 2011; Meier et al., 2006; Pollio & Ursiak, 2006; Rennie, 2012; Ward, House, & Hamer, 2009)". Nowell, Norris, White and Moules (2017, p.1) added that as qualitative research it is becoming increasingly "*recognised and valued*", and there are certain criteria which must be met in order ensure that the research meets the test of rigour. They stated that:

"*To be accepted as trustworthy, qualitative researchers must demonstrate that data analysis has been conducted in a precise, consistent, and exhaustive manner through recording, systematizing, and disclosing the methods of analysis with enough detail to enable the reader to determine whether the process is credible*" (Nowell et al., 2017, p.1).

McLeod (2001), acknowledged that qualitative interview data could yield useful information regarding the effectiveness of therapy and the effectiveness of interventions. Furthermore, Kvale (1983, p. 174) described qualitative research interviews as a process which enables an interviewer to learn about the *"life-world of the interviewee"*. By using *"knowledgeable experts"* (Tongco, 2007, p.147) as the research participants, it permitted a less constrained interview structure. Hence a semi-structured interview approach was deemed appropriate and selected. Semi-structured interviews provide a relatively open framework, which allows the researcher to follow *"topical trajectories in the conversation that may stray from the guide when … appropriate"* (Keller & Conradin, 2018, p.1).

Chapter 1 indicated that despite the passing of time, there remains a paucity of literature and hesitancy on the part of clinicians to work confidently and competently with the transgender community (Wanta, 2017). The reasons for this may be multi-fold, with one possibility being the length of time which clinicians have been practising. For

example, experienced clinicians may have commenced clinical practice when the subject was in its infancy and have witnessed the progression of a topic that was once hidden, to becoming one of the prominent issues. Also, Mizock & Lundquist (2016), posit that clinicians may well be further inhibited because they know that they have not been trained sufficiently to deal with clients presenting as transgender. While the research aims to illuminate the residual complexities and difficulties; it fundamentally seeks to understand what therapists perceive are the enablers and barriers to working with transgender clients. This will be achieved through the application of Thematic Analysis due to the structure it provides, allowing key themes to be identified from a data set.

Thematic Analysis was deemed the most appropriate research method as it can aid in the understanding of individual experiences, people's views and opinions and practices. Furthermore, can be argued that it can be used across the "*ontological and epistemological spectrum*" (the University of Auckland, n.d, para 13) and flexibly applied "*within any of the major ontological, epistemological and theoretical frameworks underpinning qualitative research*" (Lyons & Coyle, 2016. p.87). Maguire and Delahunt (2017, p.3353) noted that unlike other qualitative methods, it is *"not tied to a particular epistemological or theoretical perspective*". Boyatzis (1998) argued that Thematic Analysis is the most appropriate research method when dealing with a diverse subject matter, and the researcher aims to analyse and synthesise data from multiple participants into one meaningful account. Alhojailan (2012) noted that it also allows researchers to determine the relationship between concepts and detect and identify factors which can influence issues being investigated. Therefore, Thematic Analysis was deemed the appropriate research method for the current study.

Alternative forms of analysis were considered including Interpretative Phenomenological Analysis (IPA) and Grounded Theory (GA). IPA was considered as like Thematic Analysis it is focused on the lived experienced and aims to give research participants a voice (Cayne & Lowenthal, 2006). However, IPA is more focused on giving the voice, whereby Thematic Analysis analyses the voice, which was considered more appropriate for the current research as the aim is to understand the experiences and perceptions of the clinicians working with transgender clients. Riessman (2007) stated that Thematic Analysis might present itself as a straightforward and intuitive method of analysis, but can retain its focus on the entire story, despite deconstruction to differing themes; this was important to the research and researcher. In addition, Thematic Analysis as a method is a "*rigorous thematic approach"* which *"can produce an insightful analysis that answers particular research questions*" (Braun and Clarke, 2006, p.97).

Braun and Clarke (2006) state that Thematic Analysis is a widely used analytic method in qualitative research, and applicable within the field of psychology, yet can be rarely-acknowledged. The guidelines as set out by Braun and Clarke (2006, p. 78) were utilised as they offer an up-to-date description of the method, and are "*flexible*" and "*methodologically sound*" when applied robustly. Wigdorowitz (2018, para 3), Braun and Clarke (2014) and Attride-Stirling (2001) state that following the six steps aid's researchers in conducting a thorough, rigours and robust Thematic Analysis. Furthermore, Buetow's (2010) concept of 'saliency analysis' was also integrated as it enhances Thematic Analysis exposing themes which are non-recurrent but are of importance to the studies aims. NVivo word frequency analysis tools were utilised in order to ensure that salient themes were not missed or overlooked, due to the researchers' prior knowledge of the transcriptions thus ensuring rigour.

McLeod (2011) noted that Thematic Analysis seeks to uncover patterns of meanings through accounts of lived experiences; this was important for the research as it was the lived experiences of clinicians which were being analysed. McLeod (2011, p.45) added that *"qualitative research is always, to greater or lesser extent, a hermeneutic enterprise – where interpretation occurs, further competing interpretations are always possible*". Gross (2013) added that there are attempts to develop the method as a more systemic and robust approach for research from psychology, psychotherapy and counselling domains. However, the subjective-ness of the researcher and subject matter cannot lead to absolute truths. As a result, Thematic Analysis is the frequently used method with empirical information. Bradford and Cullen (2012) support this and add that they are most widely used within the field of social sciences.

3.3 Research Method

The research was designed with the aim of being sensitive to the transgender community and the therapists who work with them. Hermeneutics fundamental principles are based on respectful and self-conscious relationships whereby genuine interactions can be observed (Gadamer, 2004); this seems particularly pertinent in relation to the researchers' aims as it is through the exploration of genuine interactions that therapeutic nuances both enabling and inhibiting factors will be illuminated. Furthermore, Gadamer (2004) stated that presumptions, prejudice and bias thwart fundamentally genuine interactions; this resonated with the current research, as these facets can lead to the creation of understandings/misunderstanding and lead to the formation of traditions.

Staunton, Tacconelli, Rhodes and Woods (2009), stated that the transgender community is supportive of non-pathologising and qualitative research. It was the aim that this research would be supportive of both therapists and the transgender community, and highlight the barriers and enabling factors, that if addressed might facilitate a more effective therapeutic relationship/outcome.

3.4 Research Considerations

Fugard and Potts (2015), cited the guidelines for Thematic Analysis and suggested that the appropriate sample size ranges from 2 to 400 plus, with no clear direction on how to choose a value. When the participants were initially recruited, the research methodology did not prescribe a set sample size, due to the wide variety of material available for analysis. Therefore, no additional participants were recruited for the reanalysis of the data.

Ando, Cousins and Young (2014) state that it is essential when carrying out Thematic Analysis to reach saturation but establishing when that has been reached can be difficult (also see Lowe, Norris, Farris, & Babbage, 2018). Charmaz (2006) stated that the study aims are the *"ultimate driver"* of research design and sample size. Therefore a study with *"modest claims"* can achieve saturation quicker. Also, Jette, Grover and Keck (2003) noted that using participants with 'expertise' in the area could further reduce the number of participants needed in a study. Sullivan (2012) stated that in reference to qualitative methods, saturation is reached when no new themes are emerging from the data. This was supported by Strauss and Corbin (1998) who stated saturation should be assessed in terms of 'degrees' and researchers should be more concerned about reaching the point where analysis becomes counter-productive, and no-longer adds to the research.

3.5 Ethical considerations

The foundation of Counselling Psychology is built upon the British Psychological Societies (BPS), Code of Human Research Ethics (2014), the Division of Counselling Psychology (2005) and the Health Care Professional Council (HCPC) Standards of Conduct, Performance and Ethics (2016). As a result, Counselling Psychologists researching and practising under the auspices of Counselling psychology are expected to adhere to the guidelines of minimising risk and harm to others and respect the rights and dignity of participants (British Psychological Society, 2017).

Kumar (2005) stated that it is unethical to collect and use information from participants without their informed consent. Therefore, it was stated within the participant information sheet (See Appendix G) and before data collection, that participation was voluntary, and they had the right to withdraw at any time. All participants were asked to sign a consent form stating they were willing to participate in the research interview and also assured that confidentiality and anonymity would be maintained throughout the process.

Due to the nature of the research, there were no significant ethical implications as Thematic Analysis is a secondary method of analysis exploring language used. Also, as the participants are experienced clinicians and not regarded as a vulnerable population, the ethical considerations required are further reduced. Despite the participants not being regarded as a vulnerable group, the researcher was mindful that the underpinning of all ethical codes is of the participants' welfare. Therefore adjustments were made to ensure that that the research interviews took place at a time and location which was convenient for them.

Beauchamp and Childress proposed a 'Four Principles Framework' for working ethically within medicalised settings and argued for the importance and usefulness of general principles for justifying ethical judgments (Tomlinson, 1998). The Four Principles encompasses:

1) **Autonomy**: *the right for an individual to make his or her own choice*
2) **Beneficence**: *acting with the best interest of the other in mind*
3) **Non-maleficence**: *'above all, do no harm', as stated in the Hippocratic Oath*
4) **Justice**: *fairness and equality among individuals*.

These principles align with the ethical principles of Counselling Psychologists and thus with the researcher of this study. Furthermore, their practical use when making ethical decisions is *"immediately apparent"* (Aldcroft, 2012, p.1). These principles were borne in mind when carrying out the research and throughout the analysis.

One of the key ethical considerations when carrying out the research, was to ensure that the participants felt comfortable discussing their clinical work and did not feel as though they were breaching their ethics during the interview. For example, if a participant declined to answer a question, this was respected, and the researcher moved onto the next question. It was also essential to be mindful that the researcher was not only being privileged to the participants' clinical perspectives regarding their work with transgender but potentially also the clients' experiences and life-world. Therefore, it could be viewed as each participant requiring 'two sets' of ethical considerations to ensure the protection of the participant and the client group being discussed. The second level of ethical considerations was particularly pertinent throughout the analysis, as some of the clients' experiences within the medical profession could be viewed as contravening the Four Principles Framework (Beauchamp & Childress, 2001).

Additional ethical aspects addressed and incorporated into the research included all participants receiving a participant information sheet (See Appendix G) which included all contact details enabling participants to contact the researcher, supervisors and/or the University at any opportunity if they had any questions or concerns. A signed consent form (approved by BSEC) was also obtained from each participant before the interview taking place (See Appendix H). Following recruitment, anonymity and confidentiality were maintained at all times, through the use of pseudonyms for names and locations and by keeping all audio and written/typed documented in-line with data protection policies.

Throughout the research process, the establishment of rigour is of paramount importance in qualitative research from inception, through to data collection, analysis and interpretation of findings and are an integral and implicit feature. Mertens (2005) outlined nine factors of establishing rigour in qualitative research; these include persistent observation, authenticity and confirmability. Bergman and Coxon (2005), explored quality criteria and the potential role of a resource centre to establish and maintain a set of standards for qualitative research. The factors they proposed included standards around data collection, quality, analysis and validity. Both sets were key factors throughout the research process to ensure credibility and their application is explained later in the report.

3.6 Interview structure

Semi-structured qualitative interviews were considered the most appropriate method for data collection, as it allows the interviews to unfold naturally, thus offering participants the opportunity to include/discuss topics they feel are essential (Longhurst, 2009; Potter

& Wetherell, 1987). Furthermore, it allows the researcher the opportunity to gather various perspectives on the research questions related to therapists' perspectives on working with transgender clients. As interviews were the sole technique for data collection, it was necessary that the researcher to be mindful of the analysis stage from the outset – as outlined later, familiarisation with the data set is fundamental.

Ryen (2002) noted that information elicited from interviews could also give the researcher insight into how the interviewees interpret themselves and the phenomenon being studied. Despite the researcher having a guide/list of pre-determined questions, Holt (2010) noted that it would not affect the discourse gathered as the use of semi-structured interviews allows for the conceptualisation of meaning which is individual to their experiences, which aligns with the research aims.

Evans (2017, p.2) noted that the prevalent use of semi-structured interviews within the social sciences reflected their independence from a set "*theoretical framework or epistemological position*". Semi-structured interviews fit with Thematic Analysis approach, as it allows for a conversational style to be utilised which is fluid and flexible, which can enable researchers to take their lead from the ensuing dialogue (Mason, 2002) and encourages diversity within the discourse and participants (Potter & Wetherell, 1987). Flick (2009, p.2) added that semi-structured interviews allow the researcher to gather in-depth information about a person's experiences, and are valuable in gathering "*subjective viewpoints*". Furthermore, semi-structured interviews allow researchers to address pre-determined topics, while also allowing the participants to answer on their "*own terms and to discuss issues and topics pertinent to them"* (Choak, 2012).

Rubin and Rubin (1995) stated that semi-structured interviews also permit the interviewee/participant to exercise control, by declining to answer, or changing the

subject when they do not know enough to provide an answer on the topic. Therefore, it could be argued that semi-structured interviews reduce the inevitable power imbalance between researcher and interviewee (Parker, 2005). A further advantage of semi-structured interviews is through the exploration of unforeseen answers it can reveal new perspectives to the question (Breakwell, Hammond, Fife-Schaw, & Smith; 2006); thus, producing rich and authentic data.

Cruickshank (2012, p.2) noted that a participant's narrative is a "*structuring scheme*" that is utilised when people want to understand the world and themselves and their interpretation of a situation and how to talk and act in given situations. Therefore, a restrictive or defined method of data collection such as a structured interview would not necessarily elicit such rich and varied information. However, Torfing, Dyrberg and Hansen (2000 cited in Cruickshank, 2012, p.43) argue that carrying out any form of interviews taints the narrative. This is due to the researcher playing an active role in the interview, and therefore the participants' story cannot be in its *"purest form"* as the researcher is partly shaping the answers given and direction of the interview. To overcome this, the reflexivity of the researcher is critical in relation to their influence over the narrative and ensure that it is the textual analysis which gains attention and not the interviewer (Cruickshank, 2012) – this is explored further in Section 5.3.4.

The interview structure was formulated based on a review of relevant literature and informed by the researchers own therapeutic experience of working with clients who identify as transgender. As noted in Chapter 1, perceptions of barriers to the therapeutic process were evident in the case example of Client A. Further exploration of these provided the insight of clinicians' bias, prejudiced and perceptions of competence being a fundamental contributor to them not working with a transgender client.

The interview questions were designed to elicit the clinician's range of clinical experience, how they viewed transgender clients, their therapeutic approach, if they considered there to be any enabling factors or barriers to working with transgender clients and what they perceived as the fundamental needs to overcome any noted barriers. For example, question one was designed to re-affirm and explore in further detail the participants' experiences of working with transgender clients within a therapeutic setting. The questions were originally designed with a focus on post-assignment surgery as this was indicated within the literature as a higher risk phase for transgender clients (Haas, Rodgers, & Herman, 2014), which was in-line with the original research focus.

Further questions were designed to elicit information regarding clinicians' therapeutic approaches and if there were any changes in relation to these based on a client's stage of transition. It was anticipated that this question would highlight any difficulties or barriers faced by the clinicians and/or clients at these times and the impact of these on the therapeutic relationship. Question 7 and 8 were included to elucidate information regarding services, their provision, availability and whether they are meeting the needs of transgender clients. The rationale for asking these questions was to highlight whether services are meeting the clients' needs and/or acting as an enabling or barrier factor. Due to the interviews being semi-structured it allowed for flexibility and for following the participants own clinical experiences which highlighted a number of enabling and barrier factors to the therapeutic work; thus, still being applicable to the new research design.

There was no differentiation made regarding interview questions, based on the participants' profession. The rationale for not making any alterations was that the research was seeking to elicit the clinician's experiences and any differences in their profession,

was regarded as adding further depth and a broader framework to draw upon. The participant criteria outlined that participants were required to be experienced clinicians, e.g. psychiatrists, psychologists, counsellors who have/or are currently working with transgender clients in a variety of settings for five or more years. It was important that the clinicians were experienced in order to ensure that a true perspective of the challenges of working with this population was obtained and explored in depth.

Piloting or pre-testing of the semi-structured interview questions was not carried out. During the research design, there was minimal guidance found on the necessity of carrying out a piloting exercise when carrying out semi-structured interviews. Prescott and Soeken (1989, cited in van Teijlingen & Hundley 2001, p.3) noted that this is due to them often being "*underdiscussed, underused and underreported*". Mikusa (2017) noted that there are limited published studies available and those that are often omit this from their reports, impacting future research. Due to piloting not taking place, it is recognised that it impacts the study, and is discussed in more detail in Section 5.3.2.

3.7 Participants - Recruitment

The research proposal was submitted to the University of Wolverhampton School of Applied Sciences (SAS) management board which was approved (See Appendix I and J) Subsequently an ethical approval form to The University of Wolverhampton Behavioural Sciences Ethics Committee (BSEC) was submitted and granted (See Appendix K and L). Until the forms were submitted and approved by the relevant bodies, no participants were advertised for recruitment, potential participants contacted, or interviews conducted. Ethical considerations are discussed in Section 3.5. The participant information sheet (See

Appendix G) outlined the purpose of the research, participant criteria, what participation involves and the right to withdraw from the research.

Yin (1994, p.90) stated that a studies sampling strategy is crucial to the success of a study. He added that the correct participants "*not only provide with insights into a matter but also can suggest sources of corroboratory or contrary evidence*". Therefore the inclusion criteria of utilising experienced clinicians, with a wealth of empirical and anecdotal knowledge increased the likelihood of them providing both corroboratory and contrary evidence.

Participants were searched for using purposive sampling, using a systematic search with relevant search terms through online search engines (e.g. Google) including therapist, gender identity, transgender, LGBT(QI), psychotherapist and psychologist. For the research, the term 'clinicians' was demarcated to include psychologists (counselling, clinical, and forensic), psychiatrists, counsellors and psychotherapists as these are predominantly protected titles, thus ensuring a level of professional values and training, and aiding trustworthiness to their narratives.

A purposive sampling approach was used in accordance with the inclusion criteria outlined below. Purposive sampling was chosen as it allows the researcher to make *"strategic choices"* (Palys, 2008, p.697) which are connected to their objectives and research question (Willig, 2010) as the response cannot be gained from other sources (Teddlie & Yu, 2007) and selection is thus based on a specific purpose (Tashakkori & Teddlie, 2003). Tongco (2007, p.147) stated that purposive sampling is most effective when researching a *"cultural domain with knowledgeable experts"*, yet it remains robust when compared to random sampling. Allen (1971) reported in order to ensure appropriate participant recruitment; it is important that the researcher establish set criteria for

participants, and this need to be adhered to in this research, the criteria were based on clinical experience. Bernard (2002) stated that as the sampling proceeds, the researcher would become more familiar and gain enhanced skill. Tongco (2007, p.155) added that as the researcher becomes more confident with the sampling procedure, they will *"intuitively know if purposive sampling is applicable"* and *"how to find [participants]"* and *"where to find"* them. One potential disadvantage of this sampling method is that samples cannot easily be defended as being *"representative of the populations due to potential researcher subjectivity"* (Black, 1999, p.118). However, the participant criteria concerning the clinician's required experiences should assuage this.

Within the initial research, the aim was to recruit a maximum of seven participants; five were subsequently recruited and interviewed. Participant recruitment ceased after five clinicians were identified and interviewed, due to the depth of data acquired. The rationale for choosing seven participants was due to the methodology itself as outlined above and there is no directive on sample size. Braun and Clarke (2006) also note that when conducting qualitative research using Thematic Analysis, there tend to be smaller sample sizes due to the time-consuming nature of the process. Therefore, despite the re-design, the number of participants recruited and interviewed did not need to be amended. Mason (2010) reported that there had been numerous reports regarding what constitutes a sufficient 'sample size' in qualitative research, with researchers tending to avoid placing firm guidelines regarding methodological approaches and sample size.

During the initial research, the search strategy yielded a high number of therapists (clinicians), which were then narrowed down based on the number of years of clinical experience working with transgender clients as listed in their online profiles. Originally the researcher intended to recruit clinicians based within the UK. However, recruiting

participants proved to be more difficult than anticipated, with a large number of potential participants being unable to participate due to busy schedules, lack of practical clinical experience and/or feeling that they did not have the relevant experience to contribute to the research. As a result, the search was expanded to include overseas participants, (with permission from Wolverhampton University 31/01/2014 – See Appendix M). Clinicians were sought from English-speaking countries with available internet connections and those accepting of LGBT persons'. It was felt important to seek countries that were accepting of gender non-conformity, as those who are not accepting may not have been as forthcoming and not be able to offer information to aid the research. Furthermore, it was posited that non-acceptance would be a clear barrier.

Potential research participants were initially identified through online registers of practitioners such as the British Psychological Society (BPS), the UK Council for Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP) and Gender Identity Clinics for example. All overseas participants were sourced from an online registry of therapists working with transgender and gender diversity. Also, participants were sought through an online search of agencies and professionals who provide therapeutic support and counselling for people who identify as transgender or experiencing gender dysphoria. It was deemed essential that the clinicians were experienced, with the aim of them having a wealth of experience to draw upon and a broader frame of reference, to the enabling and barriers of working with this population was obtained and explored.

Also, participants were required to be aged 18 and above. The participant information sheet (See Appendix G) outlined the purpose of the research, participant

criteria, what participation in the study involved and their right to withdraw from the research.

The initial search produced an overwhelming 900,000 plus results, which included not only individual therapists but also organisations, companies, support groups, blogs, newspaper articles and websites including the NHS listing a range of therapeutic and support options. Following this, it was clear that there was a need to narrow and filter the search. The search was narrowed to focus on psychiatrists, psychologists, psychotherapists and counsellors within the United Kingdom, which was preceded by Europe, America, Canada, Australia and New Zealand when the location of participants was expanded. Potential participants were then screened to ascertain if they met the inclusion criteria before contacting them.

Following the above search and screening, more than sixty potential participants were identified. It was decided to contact them in groups to ensure that participants did not respond with a willingness to participate to then be informed that they were no longer needed as the required number had been reached. All potential participants were contacted individually and were asked to share the research information with colleagues who may also wish to take part – snowball sampling. Any interested potential participants contacted the researcher via email, as outlined in the original correspondence and participant information sheet (Appendix G). Unfortunately, none of the initial ten participants replied within the two-week specified time-scale; a time-scale was included in the correspondence, as it allowed the researcher to retain control over recruitment.

The second step involved contacting a further ten clinicians; two replied who met the criteria and were willing to participate. Step three – a further ten clinicians were contacted, and one replied; during this step, a clinician replied stating that they would be

willing to answer the questions in written format but not be interviewed due to their busy work commitments/schedule. This clinicians' information was used during the research but not counted as a research interview. It was decided to not use the written answers as a research interview as the ability to seek expansion on their experiences and perspectives was not possible. As a result, the information gained was used as supplementary information instead of a core component. Step four and five – a further twenty clinicians were contacted, none replied. Step five - a further ten clinicians were contacted, this time one replied and in the final step with one more clinician agreed to participate. Consultation with research supervisors, after step three, resulted in the decision to expand the recruitment pool to international therapists which was commenced.

The final five participants were from different countries including the United Kingdom, Northern Ireland and the United States of America (USA). Furthermore, they were from different sectors, organisations and worked with a wide range of client demographics. It was felt that having such a diverse range of clinicians would add further depth to the research. Allmark (2004, p.185) reported that within qualitative research it must "*reflect population diversity*". NHS England Research guide (2017, p.6) also notes that when using a small sample size for qualitative research, the design should aid the researcher in obtaining diverse information in order to generate "*trustworthy insight into the complex ways people think and feel*". The University of California San Francisco (2019), further support the use of diversity with research participants and notes the negative impact of such on a studies ethics and generalisability if a diverse sample is not used. Due to the location of some of the participants and time constraints, some were interviewed via Skype, and face-to-face interviews carried out when possible. Sullivan (2012) and Deakin and Wakefield (2014) noted the positive impact of the availability of technology to assist within social sciences on the recruitment of participants and the

subsequent research. Weller (2015, p.12) regarded this as "*widening participation through time-space compression*" as convenient times can be agreed for those in differing time-zones, those leading busy schedules and those in more remote areas.

3.8 Research Interviews

Four of the five research interviews were carried out via Skype. This was due to the geographical location of the participants and time-constraints both on the part of the researcher and participant. The use of Skype for carrying out the research interviews was invaluable, as it allowed the researcher to access participants worldwide, by *"nullifying distances and eliminating the need to visit an agreed location for interview"* (Rowley, 2012, 264). Weller (2015) stated that the use of digital communication methods had become more commonplace within social research and are now a crucial part of a social scientists' toolkit (Murthy 2008, Gibson 2010, Seitz 2015). Deakin and Wakefield (2014, p.605) argued that the option of carrying out interviews online should be regarded as the new "*methodological frontier*". In contrast, Hay-Gibson (2009) argued interviews carried out in person were regarded as the 'gold standard', as they afford "*thicker information body talk and communication efficiency (Rettie 2009: p. 422; see also Boden and Molotch 1994, Norvick 2008, Hay-Gibson 2009, Deakin and Wakefield 2014)*" (Weller, 2015, p.3).

Lo Iacono, Symonds and Brown (2016), recognised the benefits of Skype within research, as it allows researchers to cross territorial boundaries, break down barriers of 'time and space' (Burkitt, 2004) and access cultures otherwise not easily accessible (Lo Iacono et al., 2016). They add that while Skype offers opportunities, it also presents limitations. McDonald and Sellers-Young (2013) advocated for the use of Skype when

researching a worldwide community as it enables researchers to retain a *'transcultural'* focus, throughout the interview process and data collection. Also, McDonald and Sellers-Young (2013) advocated for the use of a range of mediums including emails in order to garner the research interview information required. Shapiro (2008) noted that reducing the distance, allows researchers to gain a greater understanding. Rhoads (2010) researched the differences between face-to-face and computer-mediated communication and found that there were no clear findings as to the superiority of other modality. However, Fontana and Frey (2008) and Cater (2011) recognised that the use of 'virtual interviewing' can present difficulties when creating rapport between interviewer and interviewee. Deakin and Wakefield (2014) disputed this noting that rapport could be more responsive. However, Whale (2017) posited that Skype interviews could hinder rapport as the small camera and focus only showing participants face, head or shoulders can limit the ability to read non-verbal cues. It is important to add that Weller (2015) reported while there has been research on the interviewer's view of using online mediums for carrying out the interview, there is a dearth of literature regarding the participants' experiences.

Prior to the interviews commencing all of the participants were sent/given a copy of the 'participant information sheet and consent form' (See Appendix G & H), before commencing the interview. Contained within the information sheet, was their right to withdraw and the process of storing their personal and research data. All of the interviews were recorded and transcribed with a transcription key (See Appendix N) into a word document by the researcher – copies of the anonymised transcripts can be found in the confidential attachment. Seitz (2015, p.4) posited that previous correspondence with participants aided in the strengthening of rapport, while technical difficulties can hinder the process and *"create a loss of intimacy"*. Due to this, email correspondence was initiated with all participants before the research in order to increase familiarity and aided

in maintaining the rapport during the research interviews and reduced the impact of disruptions due to technical difficulties. Whale (2017), warned of the difficulties with using Skype as a method of data collection, as it inherently comes with the risk of technical challenges and requires both parties to have a reliable internet connection as disconnections could potentially impede the flow during sensitive research discussions. Fortunately, when disruptions were encountered, they were only for brief moments, and due to the software being used, both the researcher and participant were aware of the loss in connection. When this had been resolved, the interview continued without any significant disruption in the flow of the narrative being provided. These disruptions can be observed within the subsequent interview transcripts. Furthermore, the researcher felt that the use of therapists as participants allowed for a quicker recovery following technical difficulties, and there was not such a loss of intimacy.

The interviews took place at a convenient time for the participants either via Skype or face-to-face, lasting on average 1 hour 15 minutes. The interviews took the format of being semi-structured (See Appendix O for interview questions), allowing the participants to discuss aspects of their therapeutic experiences which they felt were pertinent to the research. The semi-structured format allowed for prompts and at times gave the interview direction and ensured that the researcher gained a wealth of knowledge which added further depth to the research. Also, a semi-structured approach enhances the researchers' reliability as it ensures a consistent format of questioning and carrying out the interviews. There was no cap on the length of time that the interviews could take place, although the researcher was mindful of other commitments that the participants may have had.

One of the research interviews was not used for the analysis, as the participant spoke predominantly about his research despite several attempts to direct him back to their clinical work. However, they continued to deviate from the research subject/questions asked. Upon reflection of the interview, the disadvantages of having an open framework were apparent. The main difficulty being there was not room to constrain or redirect the participants' responses towards clinical experiences and not research. One possible explanation for this is what Denscombe (2007, p.184) described as the *"interviewer effect"*; whereby participants' responses can vary depending on how the interviewee perceives the interviewer. It is possible that in this case, the participant viewed the interview as an '*academic exercise'* and thus responded accordingly with their own academic experiences.

3.9 Data Management / Transcriptions

The revised approach to the transcript data was inductive Thematic Analysis in order to develop 'bottom-up' themes and is open to the participants' experiences (Braun and Clarke, 2006) and utilised with qualitative studies (Boyatzis, 1998; Fereday & Muir-Cochrane, 2006). Furthermore, it aids in avoiding assumptions and biases which may have been perpetuated within the literature and the researchers' pre-existing beliefs on the topic. Braun and Clarke (2006, p.78) argued that the approach is "*methodologically sound*" if applied robustly and have provided clear principles and steps to aid in this.

Riessman (1993) acknowledged that the process of transcription could be time-consuming and frustrating, but it is an excellent process for researchers to become familiar with the data. All of the interviews were transcribed verbatim by the researcher.

The transcription process included all utterances by both the participants and the researcher. The majority of these were non-lexical, such as 'mmm', these can be seen as offering encouragement to the participants to continue with their narrative and that the listener was following (Glesne & Pashkin, 1992). Analysis of a narrative involves the researcher becoming immersed in the transcripts which also allows for an increase in familiarisation with the text. As noted above, the data was previously gathered for application with a different methodological approach capturing the micro and macro level of verbal interactions, as it was felt this added to the interview context and protects against bias (Gill, Stewart, Treasure, & Chadwick, 2008).

Braun and Clarke (2006) noted that Thematic Analysis does not require the same degree of micro detail as other forms of analysis, so there are no set guidelines for transcription. It felt pertinent for the researcher to re-familiarise themselves with the data by listening to the audio recording and re-reading of the transcripts with a focus on the new research question. This also aided the analysis process as stage one of Braun and Clarkes (2006) model relates to the familiarisation with the data set and the importance of this (Riessman, 1993; Bird, 2005).

As noted at the beginning of this chapter, the researcher was mindful of data saturation. The decision was taken to cease interviewing after five participants as no new information/perspectives were being yielded, thus reaching saturation.

3.10 Process of analysis

Braun and Clarke (2006) provide a step-by-step six-phase guide to carrying out Thematic Analysis and cite Rubin and Rubins' (1995, p.6) who stated that the process of analysis

is "*exciting*" due to the discovery of themes and concepts which are embedded throughout research interviews. Willis (2007, p.202) noted that the process of Thematic Analysis is a "*nonlinear, recursive (iterative) process in which data collection, data analysis, and interpretation occur and influence each other*". Wong (2008, para. 4) posited that in contrast to quantitative research, qualitative methods could be regarded as a more *"dynamic, intuitive and creative process of inductive reasoning, thinking and theorising".*

Attride-Stirling, (2001), Joffe (2012) and Pollio and Ursiak (2006) all note that Thematic Analysis is the most appropriate research method when the researcher aims to discover underlying, tacit or implicit meanings. This applies to the current research, as it is an inductive driven Thematic Analysis, where the researcher aims to undercover what therapists may perceive as the enabling or barrier factors to working with transgender clients.

The six-phases posited by Braun and Clarke (2006, p.16) are emphasised as being "*guidelines*" and not "*rules*" and need to be applied flexibly in order to fit the research question and data. Braun and Clarkes (2006) guidelines are:

1) ***Familiarisation with the research data*** – helps form the 'bedrock' for the analysis stage. As the data was collected via interviews, it inherently provides good knowledge of the data before analysis. It is recommended that the researcher immerse themselves in the data to become familiar with the "*depth and breadth of the content*" which can be achieved through the 'repeated reading' of the data in an "*active way*" (Braun & Clarke, 2006, p.16). Note taking is also encouraged to aid in the coding process**.**

Before implementing Braun and Clarkes six-phases, they acknowledge that the data needs to be transcribed as this facilitates familiarisation with the data and rigour. This process had already been carried out, due to the previous analysis and therefore did not need to be repeated. However, due to the previous analysis familiarisation was internalised through the transcription process. The audio recordings were listened to multiple times to ensure accurate transcriptions were achieved.

One key facet to note, it that the research data had previously been analysed from using a different method, thus giving the researcher extensive knowledge of the data, albeit with another perspective. The implications of this can be seen as both a positive and negative, which the researcher needed to be mindful of throughout the process, mainly when coding. For example, it was important that the researcher did not revert to focusing on the previous research question and coding under previously identified themes. It was also important to ensure that the research analysis remained inductive and did not become deductive with the researcher reverting back to the previous theory on the data.

On a positive note, having been immersed in the transcripts previously speeded up the coding process. Furthermore, within this study, the familiarisation phase included re-reading the literature review and all of the transcripts with the new research question in mind. At the end of this phase, the researcher was more focused, and several initial ideas had been borne.

2) ***Attending to interesting features of the data*** **–** occurs following familiarisation with the data and generation of an initial list of elements which are relevant to the research question, identifying their meanings and recording them as codes. The codes are features of the data which the researcher has identified as interesting. It is important to note that the codes are different from the themes which are used in the analysis.

Kirk and Miller (1986, p.21) stated that the validity of qualitative research could be questioned as there is an inherent risk of the researcher seeing "*what he or she thinks he or she sees*". Therefore, the use of software packages such as NVivo reduces this risk and accuracy can be achieved through the in-built search functions, thus enabling the researcher to ensure rigour. As a result, the decision was taken to use NVivo to analyse the data, due to the reasons mentioned above and also due to a large amount of interview transcription to analyse, thus further aiding efficacy. Pope, Ziebland and Mays (2000) argued that the use of software packages such as NVivo does not make the process less time-consuming, as coding for qualitative analysis has to be done by the researcher manually. However, Sinkovics, Penz and Ghauri (2008) recognised that the use of software packages could aid in the examination and interpretation of text data. Lewis (2004) noted that NVivo is one of the most popular software packages utilised for supporting qualitative data analysis, adding trustworthiness to the analysis process. Furthermore, it is marketed as a tool for managing data such as interviews as they are unstructured and can aid researchers in identifying themes and extracting meaning from these (QSR, International LTD., 2011). Bree and Gallagher (2016) argued that other software packages could be just as effective

and outline the usefulness of Microsoft Excel to code and identify themes from data sets.

Zapata-Sepulveda, Lopez-Sanchez and Sanchez-Gomez (2012, p.381) argued that the use of NVivo, allows for a detailed analysis of specified topics set within broader themes, therefore once the data has been coded, it provides a systematic process, therefore "*increasing the validity and reliability of the study*". Richards and Richards (1991) stated that using software such as NVivo for data analysis can add rigour to qualitative research, along with "*more transparent and reliable reporting*" (QSR, International, Pty, Ltd., n.d. para. 3). In contrast, it has been argued that caution needs to be taken when using software for analysis as they are not capable of *"intellectual and conceptualizing processes required to transform data, nor can they make any kind of judgment*" (Nowell et al. 2017, p.7).

To complete this stage, the transcripts were imported into NVivo and coded using the software facilities, along with listening to the recordings as and when required to continue familiarisation and ensuring that the nuances of the narrative were attended too. Due to the analysis being inductive, line-by-line coding was used, with segments of text coded varying in length, these ranged from phrases, single sentences to entire paragraphs, thereby giving full attention to the entire data set, a factor regarded as crucial by several qualitative researchers (Boyatzis, 1998; Braun & Clarke, 2006; Joffe, 2012). It was important during this stage, to ensure that the context of what the participants said was not lost, in order to maintain validity, which was difficult at times when phrases were coded (Braun & Clarke, 2006). This resulted in the texts needing to be re-read at times during analysis and the writing of Chapter 4 – Results. A further essential aspect was

reading the transcript was to distinguish meanings both implicit and explicit along with reading between the lines, to ensure that the researcher not only attended to what was being said but how it was said, and the nuances of language and expression used. This was crucial when participants were discussing support and passing.

NVivo permits the generation of different codes from each transcript and alignment with the research question. In order to aid in this and retain focus on the research question, loose categories were used to capture relevant text sections initially. The loose categories included 'enabling factors', 'barrier factors' and 'need' and further facilitated a systematic process of ensuring that text relevant to the research question (Creswell, 2014) were analysed and categorised into themes. The process aided the researcher in ensuring that the crucial concepts of perceived enabler and barriers of working with transgender clients were kept at the forefront and therefore fit for data-driven coding. In addition, due to using an inductive approach to Thematic Analysis, open coding was used as it allows researchers to generate codes through the familiarisation and reading of documents (Elo & Kyngas, 2008), which further allows the researcher to become immersed in the data and new insights to develop (Hsieh & Shannon, 2005). Open coding refers to the researcher not having pre-determined codes but developing and modifying them as the coding process unfolds (Maguire & Delahunt, 2017).

Identifying features of the data allowed for the development of codes and sub-codes, thus providing further explanations of the barriers and enabling factors which therapists perceive when working with transgender clients. For example, there was a code labelled 'Barriers' under which there were a sub-code such as

'training' and 'language' and the code 'Enabling' under which there were sub-codes such as 'honesty, 'understanding' and 'therapeutic approach', these were then reclassified due to a significant degree of overlapping and titled under 'Therapeutic Approach'. Also, NVivo offers several additional analysis tools, one of which enables the researcher to see the most frequently used words via an illustrative word cloud, aiding the researcher in ensuring to key aspects of the data are not missed. This was utilised for each participant – please see Appendix P – T for the word clouds. Further tools include the use of Boolean operators which can aid the researcher in obtaining specific results, by cross-referencing matching words within more than one text field and allowing new data to emerge.

3) ***Searching for themes and key features of the data–*** commences when all the data has gone through the initial coding and collating phase and aids in re-focusing the analysis on the broader themes and not solely on the codes. Braun and Clarke (2006, p.82) defined a theme as an aspect of the data which *"captures something important about the data in relation to the research question . . . [that] represents some level of patterned response or meaning within the dataset*". They noted that patterns within the data set should not be pre-determined by the repetition of word frequency or other quantifiable measurements. Braun and Clarke (2006, p.10) further added that the researchers' judgement should determine them as this ensures that the themes illustrate "*something important in relation to the overall research question*". This aligned with Braun and Clarkes (2006) guidance that segments of text can be coded within multiple different themes, which are deemed pertinent by the researcher. In contrast, King 2004 argued that too many codes

could be counter-productive when the aim is to achieve clarity through the organisation and interpretation

Kirk and Miller (1986, p.21) stated that the validity of qualitative research could be questioned as there is an inherent risk of the researcher seeing "*what he or she thinks he or she sees*". Therefore, the use of software packages such as NVivo reduces this risk and accuracy can be achieved through the in-built search functions, thus enabling the researcher to ensure rigour.

During this stage, the codes in NVivo were read and reread to see if any further potential themes could be identified the preliminary analysis came up with three main categories with eighteen subcategories including fear, honesty, grief, language, past experiences, considerations and limitations. Following this, codes were combined according to commonalities as several sub-themes overlapped significantly. For example, there were several codes related to approaches to working with clients, issues arising in therapy and the need for honesty within the therapeutic relationship of both an enabling and barrier nature. Therefore, these were collated into an initial theme titled Therapeutic Approach.

The idea of combining themes was gleaned from reading several published thesis using Thematic Analysis. Within the thesis, codes were combined based on the degree of overlap and commonality (Attride-Stirling, 2001; Frith & Gleeson, 2004; Gross, 2013; Pollio & Ursiak, 2006). It is important to emphasise that the combining of codes took significant consideration, reflection and deliberation, with the urge to combine / streamline the themes resisted solely for ease of analysis. Through the combination process, further similarities between codes were identified due to similarities in expressions, use of language and metaphors.

At the end of this stage of the Braun and Clarke (2006) model, the codes had been organised into the main and subcategories.

4) ***Reviewing themes*** **–** is a two-stage process of reviewing and refining the already identified themes to the data as a whole. It is the process of checking and rechecking the identified themes against all the themes and codes identified, along with checking them against the original transcripts. Braun and Clarke (2006, cited in Nowell, Norris, White, & Moules, 2017, p.10) stated that within this phase, researchers should ensure that the themes "*cohere together meaningfully*" with "*clear and identifiable distinctions*" between them. Gross (2013, p.53) reported that within this stage "*methodical rigour come[s] into [the] process*". As outlined above some there was a degree of overlap between some of the sub-categories, which also resulted in occasional duplication of pertinent identified text. In order to reduce / prevent repetition of data presented, the eighteen sub-categories were amalgamated into ten.

Thomas (2006) noted that inductive studies generally have between three and eight main categories. The researcher identified three main categories which were felt to identify the enabling factors and barriers which therapists perceive when working the transgender clients. It is important to note that the three main categories are not explicitly titled as enabling and barrier factors. The rationale for this position was based on the depth of narrative provided by the participants, the degree of overlap between all the categories and the researcher aiming to provide a coherent and comprehensive narrative of the findings, with the focus remaining on the research question.

During this stage, the data analysis was also manually checked for any missed codes/themes. This decision was taken due to research stating while programmes such as NVivo can aid a researcher; it is equally imperative that they ensure that they "*make sense of all the data him or herself, without damaging the context of the phenomenon being studied*" (Ishak & Baker, 2012, p.102). While this did not reveal any further themes, it aided the researcher in ensuring contextuality was maintained throughout and improved the trustworthiness, rigour and validity of the findings. Maguire and Delahunt (2017), stated that theme amalgamation should be based on ensuring that they work within the context of the data set in its entirety and the final themes should be distinct from each other. They also posited a list of considerations for researchers to reflect on, before amalgamation, this was undertaken for each theme. For example, it was deemed that the clinicians' honesty, congruence, reflexivity and hesitancy were not distinct enough to be considered separate themes. Therefore, the researcher felt that they reflected aspects of barriers hindering the therapeutic relationship/process and were subsequently combined under the theme: Fear and self-disclosure, is incorporated within the Therapeutic Approach main theme.

5) ***Defining and naming themes*** **–** the penultimate phase begins when there is a satisfactory thematic data map and as it works as a double check of the themes noted in the prior stages. The stage aims to "*identify the 'essence of what each theme is about*" (Braun and Clarke, 2006, p.92). As stated above, NVivo was used at this stage was straight-forward. It is important to note that with any software used for analysis, along with the benefits also come limitations. Ishak and Bakar

(2012, p.102) noted that any software is essentially a set of tools designed to aid a researcher when undertaking qualitative data analysis. They added that it is crucial for any researcher to remain mindful that any software cannot replace a researchers' ingenuity or wisdom and the impact these aspects have on data interpretation.

Jugder (2016, p.6) noted that despite using NVivo to aid the research, researchers should carry out manual checks to "double-check the data analysis" to improve "*trustworthiness, credibility and validity of the findings".* Due to the familiarisation of the data and prior analysis, this permitted the data to be double-checked manually at an expedited rate, thereby improving the findings rigour and validity.

6) ***Producing the report*** **–** is the process of telling the data's *"story… way which convinces the reader of the merit and validity"* of the analysis (Braun & Clarke, 2006, p.23). The 'story' consists of extracts which are embedded within the analytic narrative to make an argument relating to the research question.

Gross (2013) outlined the importance of ensuring research validity when the analysis is an inductive process and carried out by a singles researcher. These points were addressed by working with a clinical research supervisor and disclosing the techniques used to explicitly state the assumptions, rationales and judgments involved in the analysis, as outlined in Chapter 4 - Results (Attride-Stirling, 2001; Braun & Clarke, 2006; Joffe, 2012). Furthermore, the validity of the analysis was checked through discussions with peers, to ensure that I was not shaping the data to meet my research

interests/preconceptions (Dallos & Vetere, 2005) or reverting to the previous research question. As outlined above the data was analysed using Braun & Clarkes' (2006) six-stage model. It is important to note that the analysis was carried out more fluidly and flexibly, due to some of the stages overlapping and the researcher having a good prior knowledge of the research data.

In summary, there were a number of considerations, reflections and revisions required following the initial research attempt. The researcher needed to be increasingly mindful of the change in the research question and the implication this had on the current chosen method of Thematic Analysis and the importance of maintaining the researches rigour. It was felt that by using NVivo and manually checking the coding that the context of the participants narrative was not lost within the coding stages adding to the trustworthiness of the findings, which are outlined in the next Chapter.

Chapter 4 – Results

4.1 Introduction

This chapter illustrates the findings and results of the research and the processes taken in order to identify the main themes and sub-themes. As outlined in the Methodology Chapter, Thematic Analysis was used to analyse the data following the six stages as outlined by Braun and Clarke (2006). It was through implementing the six stages that the following themes and sub-themes were identified and are reported as such. Therefore, the chapter aims to present the research findings in a summary form, providing the reader with a detailed exposition of how the stages were implemented to carry out a rigorous, consistent, trustworthy and critical analysis process.

Joffe (2012, p.219) stated that "*in the name of transparency, researchers need to present systematically a sufficient portion of the original evidence in the written account to satisfy the sceptical reader of the relation between the interpretation and the evidence*". The analysis is based on the information gathered from the semi-structured interviews carried out with clinicians who had worked/were working with transgender clients and based on their responses to questions regarding their own clinical experiences.

Analysis of the data using the Braun and Clarke (2006) six-stage model indicated differences between clinical experiences, therapeutic approaches, and client needs. However, there were also themes that were interwoven and emerged throughout the data. There were also a number of shared experiences, particularly in reference to working with transgender clients for a number of years and the recognition of associated enabling and barriers factors. All of the participants' narratives highlighted distinct areas for consideration when working with transgender clients, and the commonality between the

narratives was evident regardless of theoretical orientation, location, position or service offered.

In order to present the findings cohesively and comprehensively, the themes have been arranged in a progressive order, which includes a description of the major theme and includes the associated sub-themes, inclusive of data extracts which allow each participants narrative to be heard (See Table1 below). Furthermore, as some of the themes are inextricably linked due to the nature of the research topic, a degree of overlap is evident. Each theme is introduced, followed by a table summarising the Thematic Analysis results (sub-themes), and concluding with the participants' narratives illustrated by data extracts.

Table 1: Overview of all identified themes

Themes / Sub-themes		Participants
Therapeutic Approach		
	4.3.2 Therapy and its focus	5
	4.3.3 Fear and self-disclosure	5
	4.3.4 Grief	5
Clinical Training and Areas to be addressed		
	4.4.2 Training	5
	4.4.3 Co-morbidity	4
	4.4.4 Risk	5
	4.4.5 Passing	3
	4.4.6 Language	3

Services		
	4.5.1 Experiences with services	5
	4.5.2 Limitations	4
	4.5.3 Support	5
	4.5.4 Geography	4

4.2 Participant Biographies

4.2.1 Participant 1 - Claire

Claire was interviewed via Skype and identified as female. She was an experienced Counsellor accredited by the BACP based in the United Kingdom. Claire described herself as an experienced clinician, who has worked with clients who identify across the gender spectrum and has been involved in the community for over 20 years. Claire worked for different organisations for several years and at time interview was 14 months into private practice, working alongside prominent transgender organisations throughout the UK. She noted that one of her main referral sources was from a gender clinic for clients who have been prescribed hormones. Claire viewed her therapeutic approach as person-centred and viewed herself as a 'purist' to the therapeutic model.

4.2.2 Participant 2 – Henry

Henry was interviewed via Skype and identified as male. Henry described himself as an experienced clinician based in the United States of America with a wealth of experience from carrying out research and through his current place of employment, where he worked with a range of clinicians including social workers. Henry is a coordinator of a

Transgender Health Programme and was able to offer a perspective from a range of clinical experiences. He stated that he carries out Transgender Suicide Prevention Training for clinicians, e.g. medical and mental health providers. He also works with the State Department of Public Health on a phone-in organisation for persons with suicidal ideation and produces resources and information regarding transgender suicide, suicide myths, interventions and decision tree for friends and families. Henry added that within his clinical practice he works from different therapeutic modalities to meet the needs of his clients. He noted that working from a psychodynamic model can be useful at times in order to promote therapeutic change, as clients often are hesitant to approach specific issues/topics such as trauma, self-harm and risk.

4.2.3 Participant 3 – Kaye

Kaye was interviewed via Skype and identified as female. She is an experienced clinician based in Northern Ireland who has worked extensively throughout the United Kingdom. Kaye works for a charity which offers specialised counselling services, aimed at providing emotional and therapeutic support to those who identify within the Trans* spectrum, including Gender Fluid, Non-binary, Intersex, Asexual, she added that anyone who identified under the "*umbrella*" [Line Number: 10] was welcome. Kaye stated that she had worked in a variety of roles throughout her career including lecturing and was able to offer a range of perspectives from service lead, development, personal and clinical experiences.

4.2.4 Participant 4 – Martin

Martin identified as male and was an experienced clinician registered with the BACP and based in the United Kingdom. Martin worked for a number of organisations, with clients who identify across the gender spectrum. Martin also worked in private practice and was interviewed via Skype. Martin stated that his training has included psycho-sexual therapy and worked from an integrative approach which enabled his clients to take the *"the responsibility of dreaming what they want and helping them to actually start a process that …. Get them to achieve what they want*" [Line Number: 156]. Martin was clear that as the therapeutic process/relationship develops his clients' needs "*start popping out*" [Line Number: 158] and it is those need which he uses as his guide for formulations.

4.2.5 Participant 5 – Mary

Mary was interviewed in person and identified as female; she was an experienced clinician and accredited by a number of organisations. Mary worked within the United Kingdom for several organisations and through private practice. She stated that she offered counselling and support to people of binary and non-binary genders along with partners and families. Mary added that she had worked extensively with clients who are / not considering transitioning, at different stages of transition and those who are seeking to de-transition. She also provides support for partners and families. Mary stated that she worked from a person-centred therapeutic approach and was also an "*advanced accredited… sex and gender diversities therapist*" [Line Number: 6]. Mary believed that therapy is "*crucial in exploring the self*" [Line Number: 207] and advocated for all clients having a choice as to "*how they are in the world*" [Line Number: 291]. Also, Mary noted

that part of her works with clients is to increase their understanding of how different things can affect us, depending on our mental state, she added that this could be particularly pertinent when working with families.

4.3 Themes

One of the main concerns which the participants indicated pertained to the training needs of clinicians and how these are met, this informed my first theme. The participants also indicated that the language used when working with transgender clients was another factor for consideration along with the accessibility of services, therapist's own congruence within the therapeutic relationship and how postulations can be made of the client's therapeutic need. Finally, all the participants expressed the need for a change in service availability and approach, which informed the final theme.

4.3.1 Therapeutic Approach

This theme captures three sub-themes as shown in Table 2, which are ordered as *Therapy and its focus, fear and self-disclosure* and *grief*. They are clustered together as they were all deemed as having a bearing on the clinicians' therapeutic approach to working with transgender clients.

Table 2: Main Theme - Therapeutic Approach

Themes / Sub-themes		Participants
1. Therapeutic Approach		
	1.1 Therapy and its focus	5
	1.2 Fear and self-disclosure	5
	1.3 Grief	5

All of the participants described aspects of working with transgender clients which needed to be addressed in order to break down barriers and increase clinicians understanding, thus enabling positive therapeutic experiences. The participants spoke about how they each worked with transgender clients, which indicated that a range of approaches are used, and the lack of standardisation or clear therapeutic models currently available. Furthermore, it was highlighted that currently, clinical training does not place enough emphasis on working with people who identify under the LGBT umbrella and in particular transgender persons. Analysis of the themes indicated the necessity for a review of current clinical training with a view to including aspects of this population's diverse therapeutic needs, an increase in understanding of their presentation, the need of service development and approaches.

4.3.2 Therapy and its focus

All of the participants spoke about how they approach their therapeutic work with transgender clients, many stating that they work from an integrative approach, also known

as a pluralistic approach (Cooper & McLeod, 2011), with a strong underpinning of person-centred principles. There was a clear distinction between how directive the therapeutic work needs to be and how much needs to be solely client led. A prominent therapeutic consideration noted by the participants was the need for clinicians to be aware of the role of transition, and the implications this can have on the person and their family. Henry stated that from his clinical experience carrying out training, one of the main concerns raised by clinicians is on how to *"negotiate family systems*" [Line Number: 572], particularly when there are parents or spouses involved who may not be *"in agreement*" with the transition [Line Number: 576].

Claire highlighted a vital consideration and how clinicians need to be mindful that when a person is transitioning, a crucial part of the therapeutic work should be to explore not only their care pathway but also their hopes, dreams, goals and aspirations [Claire Line Number: 684 & 894-895]. Focusing on the whole person can lead to a more successful therapeutic outcome as they recognise that their transition, is only one aspect of themselves and life-course [Claire Line Number: 605-611].

Mary noted that it is important to support clients to not become "*two-dimensional*" [Line Number: 210] and feels that it is part of her role to "*encourage the development of the person, wherever they want to go*" [Line Number: 259-260]. She added that she felt having a presence within the transgender community, has aided her therapeutic work as clients know "*where [she] is coming from*" [Line Number: 392]. Martin advocated for working in the here and now and using the most effective treatment modality to aid the client. He added that at times a more "*CBT focussed or more introspective and dynamic focused*" may be required. However, this can change during the process of therapy and/or transition [Martin Line Number: 380]

In addition, Martin stated that a key facet from his perspective of successfully working with transgender clients is to *"reinforce the skill[s] of the trans-person*" [Line Number: 86], which in turn allows them to "*dream about self-realization*" [Line Number: 87-88]. Therefore, working from a person-centred approach and adhering to Rogers' core condition through recognising that clients have an internal wealth of resources and are the 'experts' on themselves, undoubtedly enhances the therapeutic process and can be an enabling factor for therapists working with transgender clients (Rogers, 1980 & 1961).

4.3.3 Fear and self-disclosure

Several of the participants noted from their own clinical experience, that there seems to be a "*fear or phobia*" [Henry Line Number: 109] experienced by clinicians when working with transgender clients about getting it wrong, to the point of being "*paranoid*" [Claire Line Number: 480]. Henry added that in relation to treatment, there is an increased fear due to a lack of knowledge. He reported that he is often asked about the impact of a client taking testosterone when anger is already an issue and a fear that it may "*make them even angrier, or even more aggressive*" [Line Number: 658-659]. Claire noted that a potential solution is for more transgender people to be involved in all aspects of the process including "*research*" [Line Number: 655]. She posited this idea as from her perspective "*on a certain level, there's only [things] other transgender people will ever know*" [Line Number: 485]. Thus raising the question of whether a clinician's gender identity from the outset is an enabling or barrier to working effectively with transgender clients?

Martin stated that from his perspective, *"transgender clients… tend to look for transgender therapists*" [Line Number: 481]. However, he added, that many transgender

therapists "*define themselves, um, therapists' for everybody*" [Line Number: 485], with a "*detachment* "[Line Number: 495] from the person they were. Martin noted that for some there is a "*silent understanding because the … the war is over… That it doesn't belong to [them]"* [Line Number: 494-495]. Thereby posing the question, does impact the level of congruence within the therapeutic relationship.

In contrast, Mary spoke openly about her involvement in the community and how this had enabled her to work effectively with clients as they had an expectation that she would "*understand…. [and] support their lifestyle*" [Line Number: 395-396]. In contrast, Kaye noted that her involvement in the community had hindered her relationships with professionals to the extent that certain doctors would refuse to accept referrals from her. There were evident conflicting views regarding self-disclosure which potential could adversely affect the level of congruence within the therapeutic relationship [Martin Line Number: 339-340 & 494-498; Mary Line Number: 391]. Participants stated that the self-disclosures related to many areas including a clinicians' gender status, experience and/or areas of competence. Therefore, raising the question does a lack of standardisation, and a therapeutic model for working with transgender clients create a further barrier to effective clinical work?

4.3.4 Grief

A sub-theme of grief was evident within the 'Therapeutic Approach' theme and was highlighted by all of the participants. From the analysis, it was evident that the participants felt that without carrying out this work, there would be a therapeutic barrier, which would hinder their client's transition and therapeutic outcome [Martin Line

Number: 173-174; Henry Line Number 179-182; Claire Line Number: 332-349] as there needs to be a "*reconciliation*" with themselves [Kaye Line Number: 245]. The participants recognised that there was a need for carrying out grief work and the importance of normalising grief as part of any transitional process.

Martin felt that grief work was "*one of the most important elements of … therapy*" [Line Number: 174] and felt without this being addressed, the process of clients moving forward was "*impossible*" [Line Number: 184]. Claire and Kaye supported this and added that with M-t-F clients "*whether they hated him, loved him or whatever. They need to… They got to grieve for that person*" [Kaye Line Number: 239-240]. Martin provided the reference of Babette Rothschild's (2000) work titled 'The Body Remembers' and stated that due to the body remembering, grief work is a *"fundamental aspects*" [Line Number: 177] of therapy and provided the analogy of opening a bottle of Coca-Cola [Line Number: 180-204].

In reference to families, Mary and Kaye noted that they are often the focus of grief work. Norwood (2013, p.24) stated that grief within families whereby a member is transitioning had been described "*as a living death, wherein the trans-identified person is perceived as somehow present and absent, the same and different, at once*". Xavier (2007) noted that parents experience greater difficult due to concerns regarding the longer-term impact in relation to employment, relationships and health. Mary added that grief work is important for "*all members of the family*" as for "*wives, partners, parents, they're losing a son, they are losing a daughter, they are losing a husband, they are losing a wife, that's how it feels*" [Line Number: 137-138]. In addition to this he recalled from his clinical experience that *"grief seemingly starts more from the maternal figure"* [Line Number: 217] and the need to grieve for "*the person they themselves wanted to be*" [Line

Number: 220-221] and also for "*not being what their parents wanted them to be"* [Line Number: 218].

Henry noted that the grief work also needs to include coming to terms with "*disappointing people, particularly parents*" [Line Number: 151] and for the "*deep grief*" [Line Number: 161] regarding the adolescence and childhood that they never had, e.g. a Male-to-Female grieving for the girlhood they never had. He added that "*unresolved grief"* [Line Number: 155] is a topic that which is not being "*dealt with, by very many clinicians"* [Line Number: 155-156], and one that needs to be done with caution and reassurance given to the client that their progress will not be halted, thereby building trust within the therapeutic relationship.

A further consideration was raised by Claire, who noted that "*grief is something that you don't always recognise*" [Line Number: 332], as it can also be fuelled by doubt. She later added that clients also need to consider if there will be loss following the transition in terms of their "*standing in society"* [Line Number: 828-829], marriage, children, home etc. and how this can be addressed. Mary provided an example, of a client in her fifties, whose family stated that they intended to cut contact if she continued with her journey, and despite later retracting this caused considerable distress to the client. Mary added that "*that sort of experience is quite common*" [Line Number: 130].

This section also linked with an increase in risk presentation and highlights the effects of 'minority stress' [Henry Line Number: 73].

4.4 Clinical Training and areas to be addressed

Within this theme, are the sub-categories which the participants highlighted as the key areas for further exploration and to address. All of the participants noted that a lack of core / mandatory training could have an impact on clinicians clinical work and also their willingness to work with issues outside of their world-view. These themes were then clustered together under the heading of Clinical Training and Areas to be addressed.

Table 3: Clinical Training and Areas to be addressed

Clinical Training and Areas to be addressed		
	4.4.1 Training	5
	4.4.2 Co-morbidity	4
	4.4.3 Risk	5
	4.4.4 Passing	3
	4.4.5 Language	3

4.4.1 Training

A common thread throughout this theme was the lack of comprehensive training currently offered within clinical programmes. Henry stated that in the USA there is "*no formal training in anyone's educational programme that, gives them any information that transgender people even exist let alone how to interact with them on a clinical level*" [Line Number: 191-193]. Martin supported this and stated that therapy in its current state, has remained at an "*embryonal level"* [Line Number: 165]. This is due to a lack of acknowledgement within some curriculums that transgender persons exist, let alone how to work with the complexities of this client group.

Kaye advocated for a change not only within clinical training programmes but from the "*foundation*" for all "*students who are studying counselling and psychotherapy"* [Line Number: 638]. She acknowledged that there are possible plans *to be "inclusive"* but at present *"they are not doing it*" [Kaye Line Number: 633], as there are no set "*requirements [for] courses to include it*" [Kaye Line Number: 640]. However, they need to mindful "*about the needs of ... future clients*" and the promotion of "*an equal conversation"* [Kaye Line Number: 643]. Martin supported this and noted that training needs to be implemented across clinical services, which includes those who make initial referrals. He reported receiving referrals which highlighted a lack of awareness of LGBT issues and contained elements of evident "*discrimination*" within them [Line Number: 124]. Henry also spoke of witnessing and hearing of discrimination from clinicians. The discrimination had included refusals to treat people and restricting/preventing access to medical care, housing and employment opportunities. He felt that as a result of the discrimination as mentioned earlier, there is a risk of creating and/or perpetuating "*clinical ignorance*" [Henry Line Number: 199-200].

Participants noted that along with having an increased understanding of a transgender client's therapeutic needs, clinicians also require training on "*what hormone blockers are and how they influence the body itself*" [Martin Line Number: 361-362]. Kaye stated that this would increase the client's insight into the impact and "*magnitude*" [Line Number: 222] of transitioning. Additional areas noted by participant's included rising sub-cultures, the use of 'Chem-Sex' (See Glossary – Appendix A) as potentially a covert method of self-harm (Martin), asexuality, bisexuality and kink (Mary), that transition is not purely related to hormones, there key social elements too (Claire), the difference between "*sexuality and gender*" [Claire Line Number: 1128; Kaye Line

Number: 653] and the implications for sexual functioning and working with families (Henry).

Henry reported that some clinicians have difficulties conceptualising that someone does not identify with the "*gender ... attached to the sex*" [Line Number: 346] they were assigned at birth and also that their gender identity is not a "*trauma reaction*" [Line Number: 359]. He added that it is important for clinicians to recognise that "*you can't untangle the childhood stuff*" [Line Number: 362-363], that the two can co-exist and that a person's "*genitals ... have nothing to with [their] identity*" [Line Number: 564-565] which is often a "*foreign"* [Line Number: 502] concept for some. This view was also supported by Mary [Line Number: 365-366].

Henry stated that further difficulty lies in the disparity between the number of clinician's requiring training and those competent to deliver it. He reported that from his experience, when offered training, clinicians are willing to learn and amend their practice and "*run*" with their increased / new knowledge [Henry Line Number: 617]. Thereby breaking down the barriers and creating a more accessible therapeutic service. Henry also reflected that from his experience in addition to training, clinicians need to have the opportunity to "*relax and talk about their own fears*" and "*their own biases*" [Line Number: 614-615], as this in itself allows for personal development and growth. Meier and Davis (1997, p. 61) note that "*in no other profession does the personality and behaviour of the professional make such difference as it does in counselling*" thus making reflective practice paramount.

Kaye reported a barrier which she had experienced with medical professionals questioning her clinical competence due to her gender-identity status; this could

potentially be a reason why clinicians are not open about their status, due to fear of criticism and judgement.

Mary argued that while there remains a training need [Line Number: 582-583], it is important that caution is taken about not solely focusing on a client's physicality in terms of hormones and genitals, due to a risk of losing sight of the client's therapeutic need; Claire also supported this. Martin added that it is also essential for clinicians to be aware, that at times his clients have needed support with a wide range of difficulties including housing and "*material things*" [Line Number: 32]. Mary advocated for training to be person-centred with an increased appreciation for diversity, and not treating differences as difficulties, but promoting acceptance of all human nature, thus breaking down barriers and enabling greater therapeutic outcomes and experiences.

4.4.2 Co-Morbidity

All the participants stated that clinicians need to be mindful that the root cause of a clients' difficulties may not be related to their gender and they should work holistically with what clients bring. Mary stated that reverting to the topic of a client's gender can at times be a "*red herring*" [Line Number: 344]. Claire gave the example of depression and stated that if clinicians "*just lump the depression on to the gender identity… [its] a big mistake*" [Line Number: 678-679]. Henry provided a further example of a client who had seen a therapist due to the loss of their mother. He reported that the therapist repeatedly assumed that the clients' level of grief was related to their gender identity and the two were inextricably linked. Kaye added an example relating to physical illness and trauma, and how clinicians can find it difficult to understand that *"trauma can affect a trans person*"

and that "*traumas aren't always linked to their gender. Trans people can be raped*" [Line Number: 660-663]. Henry provided the analogy of how a cisgender person would feel if they were viewed through a medical filter for example, with their medications, surgery history being the focus of all interactions and interventions [Line Number: 506-513].

Henry stated that some clients might not feel able to verbalise in the therapy that the clinician is "*not helping*" [Line Number: 482] due to feeling "*powerless for too long*" [Line Number: 484]. Nevertheless, Kaye offered a note of caution and stated that during their transition "*a lot of people will not talk about other mental health problems and what's going on*" [Line Number: 464] due to a fear that it may interfere with their progress. Therefore, it is an important consideration for therapists about the need to be checking their hypothesis and formulations with clients, as often "*people don't fit expectations and mental health needs to be addressed before, during and after*" [Kaye Line Number: 479-480]. Therefore, a failure to work collaboratively runs an inherent risk the wrong assumptions about treatment needs could be made (Hallam, 2015).

In addition, Mary noted that clinicians need to be aware of why clients may seek therapy, as there is a "*lot of loneliness and depression*" [Line Number: 98] and also that some of the difficulty will be "*external to them*" and "*related to other people perceptions of them, but not their perceptions of them*" [Line Number: 118-121]. She added that in her experience a few clients seek additional therapeutic support due to their gender identity but due to "*relationship issues or work-related stress*" [Line Number: 116]. Claire also spoke of similar clinical experiences, whereby levels of depression can increase due to external pressures and feelings of isolation and being trapped, this correlation has been supported by research carried out by the British Psychological Society (2013).

Furthermore, it is important to note that Henry reported that there are cases when caution needs to be taken in relation to a client's co-morbid mental health needs. He stated that in reference to Schizophrenia, it is important that the clients' mental state is stable, as adding hormones when there is already "*dissociation and hallucinations that are tactile and kind of depersonalisation* happening" [Line Number: 693-694] caution needs to be taken to rule out underlying conditions first.

4.4.3 Risk

Henry cited a piece of research carried out in 2010, which highlighted that there was a higher prevalence of suicide attempts than the "*general population ...attempt rate for adults*" [Line Number: 55-56] within his state in-particular; 0.6% compared to 41% (See Haas, et al., 2014). He stated that the rate was "*unacceptably high*" [Line Number: 65] with parental rejection cited as a prominent factor. He argued that therapy cannot "*remove the 'minority stress' trauma*" [Line Number: 215-216] but can help in providing "*relief*" [Line Number: 217] and "*helping them manage*" [Line Number: 217].

All of the participants reported a range of self-harm behaviours they had witnessed within their clinical work from self-medicating, cutting, Chem-Sex, genital mutilation, risk-taking, alcohol and substance abuse. Mary spoke about working with clients who engaged in self-harm whose identity under such a *"wide umbrella*" [Line Number: 7]. She noted that there are notable differences in the function and bodily location of the self-harm. Henry stated that the topic of self-harm could be difficult for clinicians and clients to broach and discuss. He added that there could be "*a lot of shame involved on the part*

of the clients" [Line Number: 225] and fear, which can hinder the discussion, but clinicians are "*required by law to assess for*" [Line Number: 224].

Claire stated from her experience of working with adolescents that there is an "*element of taking back control*" [Line Number: 399] and also a risk of clients verbalising suicidal ideation "*as a cry for help or as a tool to get people to respond*" [Line Number: 135]. She reported that this is always responded to by parents and the service which she works for as the clients are asked to see a counsellor. Claire added that in such circumstance's clients could then present with a "*little bit [of] resistance*" [Line Number: 159], due to therapy not being of their own volition, thus increasing the risk of them feeling powerless within clinical services, which was evident in several sub-themes. Research into the effects of mandatory therapy has identified both positive and negative effects thus indicating a potential to create further barriers (See Jarrett, 2018). The points highlighted by Claire throughout this theme raises the question of how sole-practitioners would manage these aspects, how is the distinction made between a 'cry for help' and true suicidal ideation and does this add a further barrier for clinicians considering working with clients; see Hawgood, 2015.

Martin highlighted that there are differences in "*recurrent trigger[s]"* [Line number: 580] depending on whether the client is M-t-F or F-t-M, which clinicians need to be mindful of, as it adds another degree of complexity. He also spoke about the "*mirage*" [Line Number: 60] clients can be in, and experience heightened hopelessness for the future and overcoming their presenting difficulties. Henry added that for a client who engages in self-harm there are "*very little coping mechanisms that [they] can plug in…. that's going to give them the same sort of effect"* [Line Number: 239-241]. Clinicians with limited experience may find the diversification a further barrier and

struggle to conceptualise how a person may transition and remain suicidal due to the thoughts that it would be "*better to die happy than throw dreams away*" [Line Number: 90-91].

Working therapeutically with self-harm can be a challenge for clinicians, and for some, a legal requirement to carry out an assessment but knowing how to carry this out and having the knowledge of how to proceed following this can be difficult (Henry). Some clinicians may not feel comfortable discussing this within sessions (See Ernhout & Whitlock 2014), thereby imposing a barrier to working effectively with transgender clients who self-harm.

4.4.4 Passing

An aspect which was raised by three of the participant's pertained to the anxiety surrounding clients 'passing,' this sub-theme strongly overlapped with a service development need, as it was stated that there is limited provision for assisting transgender persons in dealing with this (See Jacques, 2010).

Henry noted that in the USA, that due to proposed changes in legislation, anxiety surrounding this has increased significantly and could have an adverse effect on clients' mental health (Santora, 2018). It was reported that there is a common need within the community for support and one that many may fear to discuss, due to the risk of offending [Mary Line Number: 496-503].

Mary provided an example of hesitancy within the transgender community of commenting on a persons' degree of success at passing. She stated that the hesitancy does

not come from malice but a lack of certainty regarding the person 'trust' and mental state at that time [Line Number: 508-513]. In order to contextualise her statement, Mary added that "*we seem to have forgotten that they were children, who were afraid to look, and actually what they are looking at is female magazine and adverts aimed at females…. [Lisa: Mmm], So they try to be the Dior lady*" [Line Number: 520-522]. Henry stated that within his region, there are "*'fee for' services designed to aid in "training trans women how to dress and how to walk, how to move their bodies*" [Line Number: 415-416] in a more feminine manner. Thereby identifying a further conversation which needs to take place, but one that often does not happen, as "*people are not sure how to approach it, because there is no consistent way that clients respond"* [Henry Line Number: 401-402], Furthermore, negative experiences on the clinician's part can make them reticent [Henry Line Number: 402-405].

Henry added that passing does not solely relate to a person physical appearance, but also in respect of "*social interactions*" [Line Number: 385] and "*interpersonal relationships*" [Line Number: 386]. He raised the issue of trans women clients often not knowing "*what the conversations look like in groups of women*" [Line Number: 453] and struggling with dynamics and linguistics of such situations. Henry stated that for clinicians it is "*particularly hard"* [Line Number: 465] to support clients with this when they have not had experiences "*in that shift*" [Line Number: 465]. He further reported that in relation to gaining the above skills and becoming proficient there is not "*enough emphasis in the therapeutic work with trans people on pure socialisation*" [Line Number: 475-476], which could be attributed to the process being "*clinician driven not client drive*" [Line Number: 476-477].

Mary and Claire spoke of experiences whereby when commencing their transition, that difficulties with passing could arise, due to attempts to conform to others views and perceptions of what being transgender means [Claire Line Number: 296-297; Mary Line Number: 167]. Mary noted that from her perspective in these cases people are "*responding to social stigma and internalised oppression, and trying to present what they think is required rather than being a whole person*" [Line Number 185-187] which can lead them to almost *"de-humanise themselves*" [Line Number: 194] and not being a "c*ongruent person*" [Line Number: 294-295]. She posited that this might arise from them being "*out-grouped*" [Line Number: 433] and subsequently becoming "*lost*" [Line Number: 434]. In addition, Claire added that for trans men, passing can include the wearing of chest binders which are "*uncomfortable*" [Line Number: 471], yet may be an integral part of someone's passing. However within the summer months, this can prove more problematic due to the additional layers required (Claire) – yet again this is something which can be difficult to broach with client's and/or understand their feelings regarding this.

When the topic of support in relation to passing was raised, Mary stated that there is *"a lot of support required, not because of their transgendered-ness, but because of society, its social stigma, that, causes people um, being afraid to actually engaged in the wider world*" [Line Number: 101-103]. She added that while passing is important, she felt that there was too much focus on it, with people being "*too much focused on getting the outside right and therefore being accepted into society…., rather than on [coughs] being a congruent person*" {line Number 293-295]. She noted that caution also needs to be taken not to normalise "*transgender to the extent that we are clipping butterflies' wings"* [Line Number: 498-499].

4.4.5 Language

A common theme throughout the analysis was the need to address the language used by clinicians with clients, and also how we can aid the clients in creating their language to express themselves. Henry stated that through delivering training, it had become apparent that one of the prominent barriers to working with transgender clients was clinicians fears of "*not knowing how to ask questions and not knowing how to reassure the patient that you are not going to do them harm*" [Line Number: 288-289]. However, he noted that there are challenges to clinicians gaining an understanding of language, its uses and terminology as it is a "*really dynamically changing language system*" [Line Number: 589]. Participants advocated the need for clinicians to step inside their client's world and understand their language and ways in which they describe their gender. Mary spoke of the need for clinicians to understand how a client might be feeling about their gender identity and provided the following analogy:

"*it's like living my life behind frosted glass, knowing that nobody can see me clearly or know who I really am. It's like wearing my clothes backwards, I can manage it and get on in life and do the things that everybody else is doing, but sometimes my clothes choke me, and sometimes they chafe me and sometimes I just want to rip it all off because I am so uncomfortable all the time*" [Line Number: 348-352].

Mary and Kaye stated that gender could be as being on a spectrum (see Killermann, 2011), whilst some clients may prefer the analogy of seeing their "*gender [as] a soundwave*" [Mary Line Number: 158] and clinicians need to be accepting of that too, as the "*only binary that exists in the world is man-made*" [Mary Line Number: 152]. Claire noted that each person is unique and has their view of what transition means for them. For some it may mean *"purely getting onto hormones, others think its actually*

accepting that they are trans and for other, it can be, uh… social transition" [Claire Line Number: 50-51]. Thereby reinforcing the importance of clear language and ensuring transparency and not making assumptions based on terminology.

Claire also spoke extensively about the need for clinicians to accept that a transgender person has an internal dialogue/language which is unique to them and may make "*absolutely no sense*" [Line Number: 175] to anyone else. Claire stated that having an accessible language may empower clients to "*get across… what they really want to say*" [Line Number: 170] and enable them to "*find their own voice*" [Line Number: 950-951]. Bouman et al., (2016), recognised this and stated that it is:

"*critical that we select language that is respectful, nonpathologizing and consistent with human rights standards, taking into account its shifting and complex contextual and cultural character*" as "language is our shared vehicle for expressing and presenting our ideas, thoughts, feelings, and opinions to the world and one another" (p.1).

Furthermore, Claire noted that the responsibility of creating this language should be collaborative and not the sole responsibility of clients or clinicians. Therefore, does the lack of an agreed language inadvertently create a further therapeutic barrier between clients and clinician's, due to an inability to validate a client's subjective emotional expression when there is a language barrier?

4.5 Services

The final theme of Service arose from all of the participants noting a range of factors which can hinder a clinician's therapeutic work with transgender clients and clients

accessing them (e.g. Geography). It was deemed essential to include clinicians and client's past experiences within this theme, as it is "*crucial that old mistakes are not revisited and old prejudices rekindled*" (Heenan, 2004, p. 793).

Table 4: Services

Services		
	4.5.1 Experiences with services	5
	4.5.2 Limitations	4
	4.5.3 Support	5
	4.5.4 Geography	4

4.5.1 Experiences with services

All five of the participants retold experiences which clients had found to be negative, involving a range of professionals including mental health providers, counsellors, psychiatrists, medical providers and law enforcement. During the analysis, it was decided to incorporate these experiences into the coding, as research shows that negative experiences understandably have a lasting impact and therefore may be brought into the 'room' in future encounters through transference (Seinfield, 2002), thus potentially creating barriers from the outset. It was also felt important to include these experiences, to show how far therapeutic approaches and attitudes have progressed over time as also demonstrated in the Literature Review.

Kaye reported from her perspective that at present there was "*no trust in, in the health board*" [Line Number: 51], due to the nature of the process, which includes

'gatekeepers' and what she viewed as betrayals of clients/patients trust. Henry reported in the USA the relationship between health services and the transgender community was "*pretty acrimonious*" [Line Number: 90] and "*not very positive at all*" [Line Number: 90-91].

Mary reported several client experiences, one of whom had received "*electric shock*" [Line Number: 35] therapy; one being asked, "*so what's it like to think like a woman*" [Line Number: 162] when seeking support for transition several years ago; and a current client who was informed she "*would not get hormones until she disclosed to her father*" her gender identity [Line Number: 308-309]. Whilst Claire accepted that it was difficult for clients who are trying to access hormones to feel as though someone else is "*holding the key to [their] life"* [Line Number 114-115], she countered this by acknowledging that they are "*not sweeties, they are a serious medical, uh, prescriptions*" [Line Number: 125-126]. It also became apparent that while there have been significant changes in practices over the years, there remains room for service development and standardisation. Henry noted that within his region, there is a vast disparity between the services being offered, with some requiring "*four-hour long batteries of psychological testing*" and "*six months of therapy, before they can get access to hormones*" [Line Number: 340-341]. Mary likened the process to a 'performance' whereby "*people who experience themselves as differently gendered have to perform*" [Line Number: 245-246] in order to access treatment, yet for cosmetic body modifications procedures, e.g. tattoos, piercings, mouth surgery to look like a cat or lizard, whiskers implanted etc., this is not the case [Line Number: 247-252].

Claire noted that some organisations have a protocol whereby clients are seen by a "*psychiatrist twice and a clinical psychologist*" who ask the same set of questions,

which are then "*cross-referenced*" in order for a diagnosis to be made [Line Number: 562-564] she viewed this as a "*daunting*" Line Number: 769] prospect. Mary added that it is important to be person-centred and meet "*people as people, rather than disordered*" [Line Number: 438] and "*make [them] feel like human beings*" [Line Number: 456-457].

Henry highlighted that not all negative experiences, had involved encounters with mental health professionals, but also with employers, landlords, insurance companies and law enforcement. He gave the example of it being *"horrifyingly legal to fire someone or kick them out of their housing or not allow*" someone housing because of their gender identity [Line Number: 84-85]. Henry also stated that research had shown that 25-30% of transgender persons surveyed had reported being "*denied care in medical offices*" [Line Number: 101], with experiences of physical assault also being reported by medical personnel due to their gender identity. In relation to mental health professionals, Henry noted that in some cases there is a risk that clients may end up "*more traumatised by the system that's trained to help them*" [Line Number: 367-368]. Furthermore, Claire reported negative experiences with professional bodies when requests are made for name changes. She noted examples whereby they have refused to re-issue membership cards in someones chosen name and insisted on them having both their "*male and female on [their] card"* [Line Number: 1070], despite being able to obtain credit cards and bank accounts in their chosen name. Kaye reported similar clinical experiences, of clients not being allowed to use their middle name, as it was claimed they were "*not actually transitioning properly*" [Line Number: 401].

Kaye recalled clinical negative experience's which were informed by the geographical location of the service and the culture and values surrounding that practice. This sub-theme is linked to geographical impact under the theme of 'Limitations.' Kaye

stated that medical practices with "*strong religious values*" [Line Number: 90], had refused medical treatment to clients based on their gender identity, with the knowledge that accesses to another service would result in "*de-transition"* [Line Number: 283] and potentially foster a lack of "*trust*" with providers [Line Number: 47]; despite this contravening the General Medical Council ethical guidance for medical practitioners (General Medical Council, 2019)

4.5.2 Limitations

This theme raised a number of considerations for services and their limitations. Martin discussed his frustration at the lack of "*primary services*" [Line Number: 315-316]. He added that only being able to offer a limited number of sessions offered, was not always appropriate when working with transgender clients due to the complexity that they present with. It was clear from his perspective that having a set number of sessions was a barrier as it does not allow for resolution of the difficulties which initially led them to seek therapeutic support. This was supported by Henry who noted that constraints from insurance companies could limit the availability of "*long-term work*" [Line Number: 258] along with being allotted "*20 minutes*" per appointment/person [Line Number: 283-284] which can lead to clinicians "*distancing themselves from a client*" [Line Number: 295]. Claire added that it had been her experience that psychiatrists within her area are advocating for further emotional support sessions when working with younger clients, which was being provided.

Mary stated that she felt that the medical model was not "*beneficial*" [Line Number: 142] as being transgender should not be regarded as a "*disorder*" but a "*diversity*" [Line

Number: 142-143]. She added that with a focus on the medical and physical side of a person's transition, e.g. testosterone and oestrogen levels, the "*person gets lost*" [Line Number: 258]. Henry advocated for an "*integrated system*" between "*mental health and medical treatment*" [Line Number: 270-271].

Martin stated that he held strong opinions regarding the use of the Diagnostic and Statistical Manual, fifth edition (DSM-V) and viewed it as a tool to "*put people into boxes*" [Line Number: 457] and disliked the association with financial support. Claire noted that there were benefits to receiving a psychiatric diagnosis because without that "recognition" then "why would the NHS want to help?" [Line Number: 521-532]. In contrast, Martin added that having a psychiatric diagnosis can be regarded as "*another layer of discrimination that the trans community face*" [Line Number: 473]. A change in view of gender identity and psychiatric diagnoses is evident within the updated International Classification of Disease (ICD-11) manual, where 'gender incongruence' has been removed from classification as a mental disorder and is now incorporated within the Sexual Health Chapter (World Health Organisation, 2018). Henry noted that an additional concern from his clinical perspective was the lack of "*standardisation of gender services and gender information services*" [Line Number: 114-115] which can lead to inequalities in care (See BMJ 2018; Delahunt et al., 2016). He added that within the USA at time of interviewing, there was an "*automatic categorical exclusion of care of any kind that has to do with gender identity disorders or gender dysphoria*" [Line Number: 117-118].

Henry cited that within his own clinical experience, he has found that there were service limitations in reference to accessing some demographics particularly "*trans women of colour*" [Line Number: 727], and as an organisation, they have struggled to

rectify this. He stated that one of the main difficulties could be the cultural 'lens' in which services are created. For example, if the service is run by "*white middle class*" [Henry Line Number: 732] employees, then for some demographics that can be a "r*eally negative experience*" [Henry Line Number: 721-722] as there is a risk of "*pathologising people... for things which are very normal*" to them [Henry Line Number: 732-733]. Kaye spoke of further limitations in reference to the number of people seeking referrals/support relating to their gender identity, but services accepting referrals are not able to meet the demand, which can result in waiting lists being "*suspended for a few months*" [Line Number: 313].

4.5.3 Support

Kaye stated that she had played an active in the formation and delivery of support groups in different formats, e.g. online and face-to-face in order to ensure accessibility. However, some of the difficulties she has encountered is a lack of support post-treatment, "*after-care"* [Line Number: 26], "*counsellors who are properly trained*" [Line Number: 42], funding and convening at convenient times for facilitators and members alike. In reference to support groups, Mary stated that there is a lot of "*wrong support"* [Line Number: 236] and posited that the word 'support' should be stopped and "*alliance used*" instead [Line Number: 545], with other participants commenting the need for more advocates (Mary & Henry), mentors for young people (Claire), clearer narratives (Martin) and an increase in online support and a no division between male and female groups (Kaye).

Mary stated that within support groups, there needed to be an understanding of what support is being offered and in particular, there needed to an increase in "*understanding and acceptance of human sexuality*" and "*acceptance of human diversity*" [Line Number: 240-241]. She reported that from her knowledge of support groups there can be a "*come on in the water's lovely attitude*" [Line Number: 504] promoted within them, which in itself can be a barrier, but one not raised out of malice. Mary added this could result in those providing the support failing to acknowledge "*how desperately lonely and alone and scared people are*" [Line Number: 506-507], thereby perpetuating some of the difficulties they are encountering. Claire further noted that support also needs to be in place, for those seeking ways to tell family and friends about their true self without causing "*a rift between people [they] were close to"* [Line Number: 360], which can result in the manifestation of defensiveness and anger.

Kaye stated she felt support needs to be offered on an ongoing basis as often clients do not recognise the problems they are having and are in effect "*charging them up*" [Line Number: 152-153] which can have a "*snowball*" [Line Number: 160] effect which is when "*cracks start to show*" [Line Number: 166]. Martin offered a balanced perspective stating that learning to see the lighter side of "*one's own problems*" [Line Number: 267] can aid the healing process and viewed it as "*part of therapy*" [Line Number: 268-269] and working towards self-acceptance. In contrast, he also reported that there could also be elements of "*inside discrimination*" [Line Number: 64] within the community which can be "*difficult to accept*" [Line Number: 75], which can further create and perpetuate barriers.

Mary spoke about the separation within services as a whole between those who identify as LGBT and cisgender persons. She gave the example of public places being

referred to as "*Hetty*" [Line Number: 470] (heterosexual) or "*rainbow*" [Line Number: 473]; and praised the latter for giving "*people somewhere to go"* [Line Number: 474], but added a cautionary note that the separation may not "*constructive*" and viewed it herself as a form of "*ghetto-ising"* [Line Number: 477]. Claire added that fear is a significant barrier for transgender person "i*ntegrating socially"* [Line Number: 446], due to concerns over *"what people are going to think*" [Line Number: 447], especially in swimming pools and gymnasiums. Martin stated that the implementation of the Equality Act 2013, had publicly aided the increase in "*LGBT friendly"* [Line Number: 117] services, but questioned the extent of this within services.

Participants stated that there was a need for support for clients in relation to 'passing' with a systemic hesitancy to raise the issue from both the community (*Mary*) and clinicians (*Henry*). Henry noted that the reluctance from clinicians could be attributed to our clinical training. As their training promoted working with clients as they present themselves, and not questioning this, nor does it include teaching people the social conventions/conversations, e.g. "*etiquette of walking down sidewalks*" [Henry Line Number: 447]. In addition to this, two participants noted that post-transition there was limited support with a view that they had "*chased [their] dream and [they had] finished it and should get on with it*" [Kaye Line Number: 545-546] as they are "*sorted*" [Mary Line Number: 255]. Claire added that there are further considerations post-transitions, which can include clients desire to change not only gender but also their whole life, due to a fear of always being viewed as their previous self [Line Number: 928-933]; she used the analogy of it being a "*scar*" that they are not "*comfortable with*" showing [Line Number: 927].

Kaye stated that within her own clinical experience she had been surprised with the number of clients' post-operative who had sought further therapeutic support which she attributed to them being "*blind to what might happen afterwards*" [Line Number: 268-269]. However, she was unsure as to best method for offering post-assignment surgery services, as if hospitals and Gender Clinics offer them, then it in effect is "*keeping the cycle going"* [Line Number: 566], which has led to the development of her making "*support groups on-line and accessible and honest*" [Line Number: 589]. An interesting aspect was also raised by Kaye who noted that she does not "*create support sessions"* [Line Number: 155] with other clients of hers, in order to prevent negative experiences being retold and increasing anxieties.

Mary summarised her view of support services as being "*underfunded*" [Line Number: 582] and questioned the sufficiency of them. Therefore, she felt that it was important when reviewing and revising services, to be mindful of the strengths and *"good work*" [Line Number: 629] being done and not "*throwing the baby out with the bathwater*" [Line Number: 625].

4.5.4 Geography

Four participants raised another frustration with services which may present a barrier for clients accessing support and related to the geographical spread and accessibility of services. Henry noted that within his State, there was a good provision of services which he regarded as "*liberal and pro-active*" [Line Number: 38-39]. However, he spoke about the discrepancy between States which included differing policies for healthcare providers, in reference to funding a person's transition medical bills and how this is a significant

barrier to accessing services. Claire noted that there is a benefit to therapists offering Skype sessions when location or availability barriers are a factor. She added that this could lead clients feeling more comfortable to present themselves in their 'true' identity without the worry of leaving their home. Claire provided the example of a male client who requested a face-to-face session, but due to time constraints this was not feasible, and Skype sessions were arranged. Claire reported that during the first online session, he presented himself in his true identity, as this did not require him to leave his home which was something, he was not ready for. Therefore, working via a different medium, served to break down a barrier and enable a successful therapeutic experience for the client.

4.6 Conclusion

Throughout this chapter, the aim was to provide a coherent narrative of the clinicians' experiences of working with transgender clients, highlighting what they perceived to be the enabling and barrier factors to therapeutic work. During the analysis, it became clear, that while there are clear barriers for clinicians including the lack of mandatory training, services, a universal language and geographical restrictions, there was also an abundance of enabling factors too. These included working from a range of modalities, a willingness to learn, honesty, seeing beyond the client's presentation to the true distress being presented and a willingness to change. It was also clear that despite making great strides in terms of diagnosis, moving away from the medical model and in some cases an increasing acceptance there are a number of pervasive barriers which still exist and some of which remain a taboo subject (e.g. discussing the success of a person passing).

It was felt that the research benefitted from accessing participants from a wide range of backgrounds, and the depth of their experiences and knowledge was highlighted throughout. However, what it is worth noting, that despite the wide geographical spread of participants, there were many consistent narratives regarding the experiences of their clients, e.g. the need for training and language. All of the participants noted that access to services was difficult and there were restrictions based on religion, colour, or location all of which can hinder a client's progression through their chosen care pathway.

Through the process of conducting the Thematic Analysis what became apparent was the honesty of clinicians, to discuss their limitations, hindrances in therapeutic practice and areas where they feel as a profession we can improve. Upon reflection, there was a risk, that clinicians might not have reported any barriers to work with transgender clients, and only reported the positives in order to promote their successes and the benefits of engaging in therapy. The reflective process and other learnings are outlined in the following chapter (Chapter 5 – Discussion).

Chapter 5 – Discussion

5.1 Introduction

The purpose of this Chapter is to explore the research question in light of the research findings and within the context of the information provided in the earlier Literature Review. This exploratory piece of research has provided an insight into what therapists perceive as the enablers and barriers to working with transgender clients. This Chapter will be organised under a heading addressing the research question and subsequent main themes, in order to facilitate coherence for the reader. Finally, there is a section on reflexivity, the strengths and limitations of the research are then considered along with recommendations for future research and implications for Counselling Psychologists.

This research aimed to carry out a qualitative exploration of therapists' experiences of working with transgender clients, with a focus on what therapists perceive are the enablers and barriers to working with transgender clients. The following research question was asked:

What do therapists perceive are the enablers and barriers to working with transgender clients?

5.2 What therapists perceive are the enablers and barriers to working with transgender clients

This section of the discussion focuses on the themes outlined in Chapter 4 – Results, with the purpose of expanding further on the research question. Also, this section will also present supporting literature of the presented themes.

5.2.1 Emergent theme

5.2.1.1 Therapeutic Approach

The first theme identified, related to the participants' perspectives on the therapeutic modalities and approaches adopted when working with transgender clients. As a Counselling Psychologist (in training), an integral part of our philosophy is not to align ourselves as the 'expert' but recognise that each client is the expert on themselves and allow them to direct the therapeutic process (Joseph, 2017). The participants' narratives supported this philosophy and revealed a number of factors which they perceive as enabling factors and barriers to working with transgender clients. These factors included the therapeutic approach, including recognising the role of grief work, self-disclosure, availability of training, the need for increased awareness regarding language, and service provision.

Richards (2016), reported that a therapist's perspective regarding the medical model could have an impact on the therapeutic relationship. Joseph (2017) argued that Counselling Psychology has traditionally challenged the medical model, in order to "*retain a humanistic value base*" at its core (Douglas, 2010, p.24). In addition, Milton (2014, p.17) noted how "*Counselling psychology prides itself on its grasp of more than one narrow therapeutic literature*". Joseph (2017 p.29) added that this results in a *"breadth of expertise in multiple therapeutic approaches*". All five of the participants described the importance of working integratively and the need to be able to work with different therapeutic needs including grief, discrimination, stigma, anxiety and depression. Therefore, the breadth of training provided for Counselling Psychologists, potentially suggests they are the most appropriate therapeutic clinicians to work with transgender and gender variant clients.

Shealy (2015), stated that transgender and gender non-conforming clients seek support from mental health services for a wide range of reasons, including transition, life stressors, anxiety and depression. He added that while there are clear guidelines for best practice, there is a limited amount of literature and research regarding the effectiveness of clinical interventions, and cites only case studies as a source of reference (Ehrensaft, 2009; Winograd, 2014). Fraser (2005) recognised the diversity within mental health professionals and the impact this has on their therapeutic approach and frameworks when working with gender identity concerns.

Carroll and Gilroy (2002, p.233) argued that treatment needs could no longer be viewed as exclusively male or female, and called for a need for a 'trans-positive' therapeutic approach which "*affirms and celebrates individuals with non-traditional gender identities*". Bockting, Knudson, and Goldberg (2006, p.4) also advocated for the use of "*regular techniques*" to build therapeutic rapport, while demonstrating "*trans-specific sensitivity*". Furthermore, it has been stated that one of the most important aspects when working with transgender clients is ensuring clinicians competency which includes an understanding of "*gender and sexual identity development"* (Bockting et al., 2006, p.12) and the challenges of transference and countertransference (Milrod, 2000).

The role of fear and self-disclosure was also a prominent theme highlighted by all of the participants, with them noting the disparity between clinician's clinical work and presentation of self. There is currently a wealth of research on the importance of clinicians maintaining boundaries between their personal and professional life, with an emphasis on the use of "*social networks (Frankish, Ryan, & Harris, 2012; Grohol, 2008; Lehavot, 2009; Lehavot, Barnett, & Powers, 2010; MacDonald, Sohn, & Ellis, 2010; Malesky & Peters, 2012; Taylor, McMinn, Bufford, & Chang, 2010; Zur, 2011; Zur & Donner,*

2009), and other online media (Barnett, 2008; Behnke, 2007; 2008; Kolmes & Taube, 2010; Tunick, Mednick, & Conroy, 2011; Zur, 2008)" (Haeny, 2014, p.2-3) and also on self-disclosure regarding sexuality (Porter, 2013). In addition, there is research surrounding working with ethnic minorities and the role of developing culturally sensitive practices (Rathod, Kingdon, Phiri, & Gobbi, 2010), yet there is a dearth of literature and guidance regarding being transgender or gender non-conforming (TGNC), working with clients and the role of self-disclosure (Lurie, 2014).

It was evident throughout the analysis that a number of participants had chosen not to self-disclose their own identity or alliance with the transgender community. Lurie (2014) found that a clinician's visibility and/or lack of visibility can create a burden/fear, which is not reported by other therapists, with a greater emphasis on the role of transference and counter-transference. He added that TGNC therapists reported concerns about deceit and congruence with clients and the potential for this to rupture and or break the therapeutic relationship. Lurie (2014, p.66) cited his own participants narrative who stated that following self-disclosure there was a "*real shifting point for the relationship to feel more real and more genuine for the quality of the work to really deepen*". Elkind (1996, cited in Gerson, 1996, p.173) outlined her narrative as a therapist and client and noted how her "*negative experiences as a patient have had a powerful and positive impact on my clinical work*". This was supported by Martin's narrative [Line 494-495], who reported that there is a degree of detachment from transgender therapists when working with transgender clients that they have almost transcended their clients' difficulties as it no longer relates to them.

It could be postulated that clinicians own self-disclosure could be an enabling factor to effectively building therapeutic relationships and could facilitate therapeutic

breakthroughs (Bjork, 2004; Kolden, Klein, Wang, & Austin, 2011; Moore & Jenkins, 2012). This is also supported by Smith (2009, p.19) who posited that "*Transgendered individuals often feel more comfortable and are encouraged to disclose first to other transgendered peers who have their own experience with the challenges and benefits of disclosure*". Richards (2016) cited concerns that clinicians are not always respectful of transgender clients lived experiences, which can impact therapeutic relationships and perceptions of services such as gender clinics. Therefore, self-disclosure from therapists by could be an enabling factor by increasing "*trust, connection, willingness to be vulnerable, and, ultimately, growth*" (Lurie, 2014, p.66) or a barrier as non-disclosures confirm feelings of isolation, stigma, shame and confusion (Bockting & Coleman, 2007).

Porter (2013, p.23) added that therapists who work from a person-centred approach are more accepting to the idea of self-disclosure, thereby "*modelling openness, strength, [and] vulnerability",* thereby potentially breaking down barriers clinicians' may experience when working with transgender clients. As a result, it could be argued the role of self-disclosure could be paramount in the facilitation of the core conditions as outlined by Rogers (1957), which is a central tenet to the philosophy of Counselling Psychologists.

5.2.1 Clinical Training and areas to be addressed

Throughout the analysis, it was apparent that there may be a fear of getting it wrong and a lack of acknowledging that we are not the expert. Therefore, this may hinder clinicians from seeking additional training or admitting to the clients, that they may not be the best therapist for them. Richards (2016) cited a number of studies that identified a lack of training on LGBT issues across the professional spectrum including psychotherapists,

nurses which has resulted in an unfamiliarity of their needs (See Kendall-Raynor, 2016; Lombardi, 2001; Morrow, 2000; Pachankis & Goldfried, 2004; Rutherford, McIntyre, Daley & Ross, 2012; Singer, 2013; Wilson, et al, 2014). A report published by GIRES (2019) highlighted that despite some health care professionals recognising the importance of increasing their knowledge base and utilising available training, this is not common practice. They outlined how they developed training for the Royal College of General Practitioners (RCGP), however, unauthorised changes were made "*undermining the responsibility of GP's;"* thereby disseminating disingenuous information which could adversely impact the transgender community (GIRES, 2019, para.2). As a result, the training was not facilitated and removed from the RGCP e-learning website. The need for further training is noted as a recommendation in light of this research in Section 5.4.

During the interviews, Claire reported that she had questioned her own skills at times when working with under 18's, which has left her feeling "*inadequate*" at times [Claire Line Number: 502] due to not having knowledge of their world-view. She added that clients have reported that they have seen clinicians who have stated that they are unable to work with them due to not being familiar with their presentation/needs. This is positive as clinicians are bound by ethical guidelines and should work to the principles of beneficence and non-malevolence and working in the best interests and well-being of their patients (Kinsinger, 2009). Mizock and Lundquist (2016) reported that a number of clients felt that they were educating their therapist in relation to TGNC issues, for the therapy to progress. This again highlights the lack of training incorporated into clinical training and the importance of this being addressed (See Future Research and Recommendations – Section 5.4). However, it is important to note that clinicians registered with the Health and Care Professions Council (HCPC) and British Psychological Society (BPS) are required to engage in ongoing 'Continuing Professional

Development' (CPD) in order to *"maintain and improve our professional competence' (Miller, 1990)"* (Golding & Gray, 2006, para.3).

A further consideration for clinicians rests not only with the need for additional training but also for appropriate clinical supervision. Nichols (2018) recognised that the supervision of therapists working with transgender and gender non-conforming clients requires consideration and presents its own challenges. Therefore, it is important that therapists not only receive/undertake training on working with transgender clients but also can receive appropriate supervision in order to maintain clinical efficacy and competency.

In addition, during the interviews, participants emphasised the importance of working holistically with clients and not solely focusing on their gender identity, thereby preventing them from becoming "*two-dimensional*" (Mary Line Number: 259-260). Clarke (2018), stated that clients had reported negative therapeutic experiences when therapists have solely focused on their gender and not on other aspects of their life, or in contrast have not focused on it enough. In response to such cases Bockting et al., (2006, p.6) emphasised the importance of ascertaining client's personal strengths and support in order to reinforce their sense of "*competency and agency*" and view their life holistically including *"psychosocial adjustment*". Murphy (2017, p.27) noted that the roots of Counselling Psychology are based on "*nurturing people's strengths and tale*nts". Vossier, Steffen and Joseph (2015, p.431) added that Counselling Psychologists take a *"holistic perspective on human beings, which includes valuing and respecting subjective-and-intersubjective experience*".

Furthermore, three of the participants spoke about the importance of language and the need for a collaborative approach regarding it, to promote inclusivity and self-

expression. Langer (2019, p.32-33), recognised in relation to language, the subject of gender is "*difficult to articulate*" and can be inadequate when expressing the "*experience of self*". As a result, this can place a greater burden on transgender clients, who are required to articulate their experience of self in order to access aspects of medical treatment. Richards (2016, p.22) noted that from a client's perspective difficulties with language and communication can create a fear of being misunderstood and clinicians may fear "*appearing ignorant (Neal & Davies, 2000)*".

As a result of the above-outlined difficulties, Richards (2016, p.22) argued that Counselling Psychologists would be best placed of offer therapeutic assistance as they endeavour "*to get 'alongside' the client to explore their world phenomenologically*" and not rely on the traditional scientist framework.

5.2.2 Services

All of the participants reported that their clients had positive and negative experiences with service; this was also discussed in Chapter 1 – Literature Review and within Section 5.2.1 of Chapter 5. Hunt (2014) argued that there is limited empirical research exploring why transgender clients seek therapeutic support outside Gender Identity Clinics in the United Kingdom. She found that a good therapeutic relationship was a crucial element for a positive therapeutic outcome and experience, as reported by clients themselves. Barriers were reported as arising from fear of being misunderstood, judged and uncertainty within the therapeutic relationship (Hunt, 2014).

One aspect noted by four of the participants pertained to the geographical spread of services and the impact this can have on clients. Within the United Kingdom until the

end of 2018, there was a recognised barrier for transgender clients living in Wales accessing Gender Identity Clinics and healthcare, due to them being based in London. Gallagher (2015) reported there were seven clinics throughout the United Kingdom, with over 4,000 people on the waiting lists; thereby creating geographical implications and barriers to access healthcare. The All Wales Gender Identity Partnership Group (AWGIPG) was formed in 2017 with the aim of addressing a number of issues including the *"gaps in provision of locally delivered services"* and the *"quality of care and patient experiences"* (NHS Wales, n.d). The Brackenburn Clinic in Belfast also reported a two-year waiting list for an initial appointment with the Regional Gender Service (Belfast Health and Social Care Trust, n.d). Pearce (2018) reported a range of waiting times in the UK ranging from 42 weeks in adult services and 21 in children and adolescent services to an average of four years.

Davidson and Rieke (2016, p.12) presented a paper exploring the barriers to accessing care within the United States and reported a number of systematic issues including a "*lack of provider transgender-specific knowledge*" and "*cultural sensitivity among providers*". They added that in order to address these barriers a there needed to be an increase in funding, services, cultural competency, and the use of appropriate language (Davidson & Rieke, 2016).

All of the participants reported that clients had had negative experiences with professionals previously which has led to a degree of traumatisation over the years. It also became apparent that while there have been significant changes in practices over the years, there remains room for service development.

5.3 Strengths and Limitations of the Research

As outlined throughout Chapter Three, consideration has been given to ensure the research is trustworthy, reliable and rigorous. This section also outlines the strengths and limitations of the research, with reference to the sample size, interview process and analysis method.

5.3.1 Critique of Sample Size

As outlined in Chapter Three (Section 3.7), the sample used was small and consisted of five participants. However, the aim was to explore the individual experiences of clinicians and claims regarding the representativeness of the sample or generalisability of the results are not being made. Nevertheless, the research allowed the voice of clinicians working with transgender clients to be heard, and an exploration of their perspectives on the enabling and barriers to working with these clients to be undertaken. Despite the small sample size, the research can allow clinicians to reflect, and develop ways of moving forward and overcoming any barriers in their own clinical work with transgender clients. In addition, despite a small sample size, the participants were from a range of backgrounds, disciplines and countries and the existing literature has supported the majority of emergent themes; thereby affording a degree of generalisability to the findings.

5.3.2 Critique of Data Collection Tools

The use of semi-structured interviews allowed the participants the opportunity to share their experiences and perspectives of working with transgender clients in a non-prescriptive manner and allowed them to discuss aspects which they felt were pertinent to the research. However, the use of semi-structured interviews as a method of data collection, researchers need to be mindful of the influence of the interviewer, interviewee, the interaction between the two and questions content (Cohen, Manion, Morrison, & Morrison, 2000). These considerations were discussed in further detail within Chapter Three – Section 3.8. Kirkbride (2012) also reported that the use of semi-structured interviews might inhibit a participant's ability to recall and express themselves, thereby affecting the portrayal of their experiences. In contrast, Vaismoradi, Turunen & Bondas (2013) argued the approach seeks to understand experiences with the participant's narratives and not quantify the data, therefore the use of semi-structured interviews still facilitates the researchers understanding of the participant's experiences from their narratives.

In addition, as noted in Section 3.6 piloting or pre-testing of the semi-structured interview questions did not take place. It is accepted that in hindsight, carrying out a piloting exercise, may have prevented the previous research failings as adaptations to the study could have been made. van Teijlingen and Hundley (2001, p.1) reported the benefit of piloting lies in its ability to "*give advance warning about where the main research project could fail, where research protocols may not be followed, or whether proposed methods or instruments are inappropriate or too complicated*". In contrast, it has also been argued that carrying out piloting exercises can impact data collection and subsequent

analysis due to the progressive nature of qualitative data collection, and are therefore not regarded as necessary (Holloway, 1997, cited in van Teijlingen & Hundley, 2001).

Bradley (2016) noted in her own research, psychotherapists were hesitant to acknowledge difficulties within their clinical practice when working with TGNC clients. However, Harmon and Donohue (2018) found that his participants were more open to discussing difficulties encountered within the therapeutic relationship with TGNC clients. Therefore, it could be posited the research questions used within the current study, were framed in a way which facilitated participants to reflect on their own clinical work and that of the profession as a whole, by also addressing service needs.

5.3.3 Critique of approach

The use of Thematic Analysis facilitated the identification and reporting of emerging patterns and themes within the data set. As noted in Chapter Three (section 3.2 & 3.3), Thematic Analysis is independent of any particular "*epistemological or theoretical perspective*" (Maguire & Delahunt, 2017, p.3353). Consequently, it has been criticised for being vague (Holloway & Todres, 2003) with an unclear process of analysis (Attride-Stirling, 2001) and allowing "*researchers to select extracts to support themes the researcher would like to see, therefore lowering the validity of the research*" (Kirkbride, 2012, p.118). In addition, it has been "*seen as a poorly 'branded' method; in that it does not appear to exist as a 'named' analysis in the same way the other methods do (narrative analysis, grounded theory)"* (Patel, 2016, p.54). In defence of the Thematic Analysis method, is the fact that the process is inductive, data-driven and developed 'bottom-up' from themes identified by the participants' narratives (Braun and Clarke, 2006) with the

aim of increasing understanding of human experiences. Moret, Reuzel, van der Wilt, and Grin (2007, p.25) argued that qualitative research is aimed at knowledge and seeks to understand participants "*version of the truth*".

The use of NVivo software to carry out the analytical process was invaluable. However, due to a lack of familiarity with the programme, the researcher was concerned about maintaining the data's context, during the coding process. As a result, the researcher was meticulous in ensuring that during the writing phase of the research, the context was checked to enhance the research's credibility (Patton, 2002 cited in Salzmann-Erikson & Soderqvist, 2017).

A further consideration is the impact of the data being previously used for a different research question and method of analysis. Cheng and Phillips (2014) noted that secondary analysis of existing data had become a popular choice within health research, with one of the main approaches being 'data-driven' analysis. Boslaugh (2007), Demscombe (2010), Johnston (2013), and Perez-Sindin Lopez (2013) reported that one of the main disadvantages of secondary analysis is the pre-existing data was not collected to address the new research question, furthermore generally it is not the same researchers carrying out the secondary analysis (Cheng & Phillips, 2014). However, with the current research, these disadvantages do not hold the same weight or level of concern. The rationale for this is that whilst the pre-existing data set was not initially collected with the aim of exploring therapists' perspectives on the enabling and barrier factors to working therapeutically with transgender clients, it aligned with it more than the original focus. Secondly, it was the same researcher carrying out the secondary analysis, therefore voiding concerns regarding the risk of new researchers lacking awareness of "*study-specific nuances or glitches in the data collection process that may be important to the*

interpretation" (Cheng & Phillips, 2014, p.374). As a result, of the aforementioned aspects and the audit trail of how the Thematic Analysis was conducted (Section 3.10), the impact on the validity of the research should be decreased.

5.3.4 Reflexivity

The role of reflexivity has been increasingly recognized as a key principle in the process of generating knowledge through qualitative research (Berger, 2013), and involves an awareness of the researchers own background on the process (Robson, 2002). Fereday and Muir-Cochrane (2006) argued that when using Thematic Analysis, reflexivity is an integral part, Patel (2016) also noted that it could aid in ensuring the trustworthiness of the analysed data. Malterud (2001, p.483-484), stated that "*a researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions*". Therefore, reflexivity is imperative for researchers at every step of the research process, as their own experiences can affect the ways in which you view the world (Markham, 2017, para. 30). Cutcliffe (2003, p.137), noted that a researcher's awareness of reflexivity could aid in the "*credibility of the findings by accounting for researcher values, beliefs, knowledge, and biases*".

Reflexivity can be challenging at times, particularly when the researcher is exploring participants professional and personal perspectives on a subject matter (Finlay & Gough, 2013). A way of managing such challenges has been posited by Ahern (1999) who explained a process referred to as 'bracketing'. The involves "*an iterative, reflexive*

journey that entails preparation, action, evaluation, and systematic feedback about the effectiveness of the process" (Ahern, 1999, p.408). These considerations were important throughout both research design and analysis processes, as evidenced in Chapter 1 which highlighted the emotive response the subject matter has presented for the researcher.

Due to the emotive nature of the research, both as a trainee Counselling Psychologist and researcher, a reflexivity journal was created to aid in the trustworthiness of the data. McLeod (1999) suggested three keys areas to focus on when keeping / writing a reflective journal; these included:

1) **Pre-understandings and expectations** – at the beginning, note what you expect to find; this can aid in ensuring the research "*is not an exercise in self-fulfilling prophecy*" (McLeod, 1999, p.75).
2) **The experience of doing the research** – McLeod (1999, p.75) also referred to this as "*fieldwork notes*", whereby the researcher journals how it feels to be a researcher, feelings about participants and any critical incidents.
3) **Personal and professional implications** – why was the research subject is chosen, researcher involvement in the process, implications for own clinical work and personal learning.

The journal was also paramount during reflection on where the research failed previously and hopefully aided the current research in meeting its new research aims. As noted in Chapter 3, the researcher already had a thorough knowledge of the data set ahead of carrying out the current research. Consequently, this added pressure to ensure that the research did not revert to the previous focus and also it did not become a self-fulfilling piece of research based on the previous findings. The reflexive journal was also used to document current clinical experiences of working with several adolescents who identify

as gender fluid and transgender. The journal enabled reflection on barriers to current clinical work and the applicability of the research to addressing these. One of the main barriers faced was the lack of provisions and services to support adolescents within inpatient Child and Adolescent Mental Health Services (CAMHS).

To ensure rigour throughout the analysis, a clear and systematic framework for carrying out the Thematic Analysis was used as outlined in Chapter 3 (Section 3.10) in order to counter the perception by some that *"anything goes"* (Braun & Clarke, 2006 cited in Houghton & Houghton (2018, p.3522). Braun and Clarkes' (2006) six-stage framework was adhered to, with the aim of addressing potential difficulties regarding reliability and validity within the analytical process (Koch, 1994).

5.4 Further Research and Recommendations

Reviewing the relevant literature (See Chapter 2 – Literature Review) and the findings of the current research indicate a lack of core clinical training relating to working with gender diverse clients and the need for an increase in the efficacy of services across the healthcare spectrum. Therefore, future research could focus on the role of professionals' guidelines and standardised care models for minority groups and their impact on therapeutic outcomes; with a view of aiding the conceptualisation of a therapeutic model specific for working with transgender clients. In addition, in light of recent concerns regarding the role of services with youths seeking to transition, there is a need to "*fully consider psychological and social factors in a young person's background*" (Doward, 2019, para. 7); therefore, further research could aid in the understanding of influences surrounding a person's decisions to transition.

A further consideration for future research lies within the role of self-disclosure and the therapeutic relationship. Porter (2013) explored the role of sexuality within the therapeutic relationship and self-disclosure. Shipman and Martin (2017) have explored the role of self-disclosure by transgender therapists within marriage and family therapy. However, due to the gaps in the literature and the points raised by the participants throughout the current research, an area for future consideration lies in the impact of self-disclosure with transgender therapists and clients.

In order to further support the findings within the literature review and this research, in reference to a lack of inclusivity and emphasis regarding LGBT within core clinical training, it is recommended that provision is made for those undertaking core training and qualified clinicians across the spectrum. It is important that the training should be provided by clinicians who are well versed with the therapeutic needs of the LGBT community, in particular, transgender persons'. It is also vital that those leading the training have not only theoretical knowledge of the therapeutic needs but also practical experience. This would aid in ensuring that the training is accurate and a true reflection of the therapeutic needs of the community. For clinicians who are post-core clinical training, there is a wealth of online and in-print sources including regulatory bodies, therapy magazines / journals, websites and advertising portals where the training could be advertised. In addition, ensuring the course is Continual Professional Development (CPD) accredited could further attract clinicians as ongoing learning and development is a core component of HCPC regulations within the United Kingdom. Furthermore, attracting clinicians who provide clinical supervision would also be paramount, to ensure further dissemination of the knowledge and promotion of the available training to support clinical interventions.

5.5 Conclusion

It was the initial aim of this research to provide a narrative evidencing the participants' perspectives supported by existing literature regarding the enabling and barriers therapists perceive when working with transgender clients. However, when approaching this Chapter, it became clear that providing a cohesive narrative and making a clear distinction between the two factors would not possible. As evidenced throughout Chapter 4, a large proportion of themes including self-disclosure, availability of training, use of language and chosen theoretical orientation had a bearing on what clinicians may perceive as enabler or barriers to their therapeutic work. For example, in relation to therapeutic orientation, one practitioner may feel comfortable working from an integrative framework (e.g. Henry) to meet their clients' needs while others may be a purist to their chosen modality (e.g. Claire – person-centred). As a result, one therapist may find working in a more directive manner a barrier at times. Therefore, due to the inability to clearly differentiate between enabling and barrier factors, it is important to remember the role of individuation, personal perspective and clinical experiences – what one therapist may perceive as a barrier may be an enabler for another. However, what is hoped is that this research has illuminated the range of enabling and barrier features that clinicians can encounter when working with transgender clients. Thereby highlighting aspects which may enable clinicians to 'walk the middle path' (Rathus & Miller, 2000); such as the need for ongoing training, the importance of the therapeutic relationship and working from a person-centred foundation with clients.

What became apparent throughout this research, was how the philosophical underpinnings, training and approach of Counselling Psychologists aligns with the therapeutic needs of transgender clients. In order to understand this further, exploring the

foundations of other disciplines illuminated the synergetic relationship between Counselling Psychologists and transgender clients. Joseph (2017) reported that the first clinical practitioners were heavily influenced by psychiatrists of the time and worked under their direction. As a result, the focus was on the administration of psychometric assessments and not therapy led, as this was carried out by psychiatrists who were influenced by "*psychoanalysis and trained in medicine*" (Joseph, 2017 p.23). This, in turn, influenced clinical psychologists' therapeutic stance, which resulted in their practice being embedded within the medical model leading to a "*proliferation of "mental illnesses and to the pathologization of the human existence"* (Maddux & Lopez, 2015, p.418). As Counselling Psychology did not emerge from the shadows of psychiatry (Joseph, 2017, p.26), it has been in a position to challenge the traditional reliance on the medical model, and focused on the social psychological processes that underpin a person's "*distress and dysfunction*." Hunt (2014) stated that TGNC clients need to receive the same therapeutic experience as cisgender clients. Therefore, Counselling Psychologists can look past a clients' mental illness and see the person, which creates an environment whereby barriers to the therapeutic work can be broken down, leading to successful therapeutic experiences and outcomes with clients and clinicians.

McLeod (1999) argued that research is rarely precise enough to be applicable to individual clinical cases or specific groups of people. He added that clinicians need more practice-orientated research, which will guide them on how to work with specific clients and be less "*generalised and schematic"* (McLeod, 1999, p.6). It was the aim of this research, to be practice-orientated and aid in therapists with their direct clinical work with transgender clients and it is hoped this has been achieved.

Chapter 6 – Reflective Appraisal

The research process involved in completing this Doctorate is best represented in stages, from commencing the programme of study, to developing a research idea, planning, implementation and data analysis. The trajectory through the stages was not always straight forward, but throughout it all, I found my development as a practitioner and researcher had increased, and I learnt valuable skills and lessons along the way. The reflective appraisal will provide an overview of the insights gained and lessons learnt along the way, how these informed the research process and have contributed to my development as a researcher and a practitioner nearing qualification.

It seems prudent to contextualise where the research idea was borne, how it developed along with myself throughout the Doctorate and also my own gender identity. I became interested in working with the transgender community, in my first-year placement, within a secure in-patient setting. I learnt early on that for some practitioners, the idea of working beyond their own 'norms' and clinical frame of reference was something they found difficult. As a result, when the first transgender client was admitted into the service, a proportion of practitioners were hesitant to work with them, due to the patient falling within the outliers of their own frame of reference. There was also a degree of uncertainty about how to approach the therapeutic relationship/work and a fear of saying the wrong thing. However, as a trainee and being thirsty for knowledge and experience, I was more than happy to work in this area (under close supervision) and carry out the necessary research in order to appropriately work with the client.

In reference to my own gender identity, I identify as a heterosexual female. I have always been sure that I was female and never questioned this. However, my gender and

sexuality have been questioned over the years predominantly by others, based solely on my appearance, interests and relationship status. As a child I never played with dolls (Barbie's or action men), I didn't dress in a particularly feminine or masculine manner; favouring my own 'quirky' individual sense of style which was embraced by my parents. However when at school, my 'quirkiness' was frequently used as a tool to bully me, often including comments on what they perceived my sexuality to be. Having short hair throughout my youth, I would often be informed that I was in the wrong public bathroom, referred to as a 'boy' and repeatedly told that I could be pretty if only I grew my hair. At the age of 17, I learnt to ride a motorcycle, thereby prompting further speculation about my sexuality and gender, as fellow bikers would often remark "*Oh it's a girl*" upon taking my helmet off. As a result, of riding a motorcycle, having short hair, not being particularly feminine and single, I received multiple comments that the only conclusion was I must be gay. Whilst these comments grew less hurtful over time, there was never an occasion when they did not hurt. I am not comparing the extent of my own experiences to those of the transgender community, however, I can understand the urge some may experience to conform to others expectations and views and sticking to your own path can be difficult and challenging at times.

As my Doctorate training and clinical work progressed, I also learnt many lessons including; acceptance is not always found in the places you think it would be; professionals do not always have the answers, failure is an important learning curve and the journey of self-discovery, true identity formation, acceptance of that identity and ultimately asserting it requires a great deal of strength, courage and determination.

My clinical work gave birth to the initial research idea, but as noted throughout this research report, it failed to deliver the desired outcome and required re-

conceptualising. I thought the first time was hard, but the second was harder. Initially, it was incredibly difficult to accept that I had failed and the process needed to start over again, in order to achieve my dream of becoming a Counselling Psychologist.

The reconceptualisation of the research process, was difficult initially, as it was easy to fall back into the mind-frame of viewing the data with the previous research question and not staying true to the new focus. In order to overcome this, I took some time to heal, re-group, re-focus and find my passion once more. The one reference that stayed with me was the work by Staunton, Tacconelli and Woods' (2009) who stated that the transgender community support non-pathologising and qualitative research. This was a good start the first time and was a good starting place once more. I was still passionate about making a therapeutic difference to the transgender community and to the field of psychology. Reviewing the data gathered, reminded me that it was rich with insights and clinical experiences and therefore lent itself to an exploration of therapists' perspectives of difficulties encountered when working with transgender clients. Thus, the new research was borne, and further reading of academic papers, journals and documents published was undertaken, which highlighted the positive and negative experiences of both clinicians and transgender clients accessing services.

Using a reflective research journal and supervision both research and clinical was invaluable during this process. It allowed me to reflect on the previous research experience, where it had gone wrong and my feelings of anger and grief about the process, which were impacting the current research. During the first experience, I needed to be mindful about not projecting my own thoughts, preconceptions and theories onto the data. However, this time I needed to ensure that I was not projecting the anger and disappointment, I felt about myself onto the research in its entirety. This led to the

decision to step away from the research for a while and focus on my clinical work, which I am very passionate about and it in-turn re-ignited the desire to complete the research, learn from my mistakes and do the best I can to become a Doctor in Counselling Psychology.

The entire research and Doctorate process has been one of the most difficult undertakings of my life and one that at times I thought would break me. However, I do feel that it has enabled me to grow and develop into a competent clinician and scientist-practitioner. I am very fortunate that my work affords me the opportunity to see the difference that clinicians including myself can make to the lives of those experiencing psychological distress, the benefit of a good therapeutic relationship and the importance of the core conditions in bringing about psychological change. The process has allowed me to realise that 1) a persons' identity does not need to change the therapeutic intervention or approach, the core humanistic principles are applied in the same way; 2) mistakes will be made regarding terminology, but honesty regarding this is the key to success. Transgender people are, naturally expert about their own situation and experiences. Therefore, we should be guided by them and by the language they use and 3) there is a vulnerability to life stressors within the transgender community which can exacerbate psychological and physiological distress; these are areas which remain under-researched and only marginally understood. It was the latter point that led to the inception of this research.

At present I work in a child and adolescent mental health service (CAMHS), this in conjunction with carrying out the research, has made me realise that there may not always be clear guideline or manual on how to work with a client's presenting difficulties, but for me the skills learnt throughout my training are a solid foundation and transferable

to a wide range of clients. In addition, this research has made me proud to be a Counselling Psychologist (in training) who when presented with therapeutic barriers, we as a profession are leading the way to seek out ways to overcome them and work with clients of all demographics to make that positive difference. It is hoped that at the end of this journey, this research will empower other clinicians to reflect on barriers in their therapeutic work and seek out ways to overcome them.

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Appendices

Appendix A – Glossary

Affirmation therapy	Affirmative Therapy is an approach to working with gender diverse clients which affirms and supports individual gender identity, expression as well as how that intersects with other areas of lived experience. Affirmative therapy is an intentional positioning of gender diversity as an inherent part of the vibrant diversity of being human.
A-gender	A-gender is a term which can be literally translated as 'without gender'.
Aversion Therapy	Aversion therapy is a behavioural treatment intervention based on the principles of classical conditioning and behavioural psychology. It is sometimes referred to as conversion therapy or reparative therapy. The goal of aversion therapy is to eliminate bad habits, self-destructive behaviors, or other undesirable behaviors (e.g. nail biting or alcohol abuse) by pairing the behavior with an unpleasant stimulus (e.g. medication-induced nausea or an electrical shock)
Binding	**Methods to flatten breast tissue to create a male-appearing chest**

Bi-gender	**Bi-gender** or dual gender is a gender identity where the person moves between feminine and masculine gender identities and behaviours.
Breast Augmentation	Breast augmentation are plastic surgery terms for the breast-implant and the fat-graft mammoplasty approaches used to increase the size, change the shape, and alter the texture of the breasts of a woman
Chem-sex	Chemsex is a term commonly used by Gay men and Men who have sex with Men (MSM) to describe the use of certain drugs in a sexual context
Chondrolaryngoplasty	A surgical procedure in which the thyroid cartilage is reduced in size by shaving down the cartilage through an incision in the throat
Cisgender	Someone whose gender identity is the same as the sex they were assigned at birth. Non-trans is also used by some people.
Clitoroplast	Any plastic surgery procedure on the clitoris.
Conversion therapy	Conversion therapy (or 'cure' therapy or reparative therapy) refers to any form of treatment or psychotherapy which aims to change a person's sexual orientation or to suppress a person's gender identity
Cross-dresser	People who wear clothing, jewellery, and/or make-up not traditionally or stereotypically associated with their anatomical sex, and who generally have no intention or desire to change their anatomical sex. Cross- dressing is more

	often associated with men, is more often engaged in on an occasional basis, and is not necessarily reflective of sexual orientation or gender identity.

Electro-convulsive therapy	Electroconvulsive therapy (ECT) is a procedure, done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental health conditions.
Facial Feminization Surgery	See Surgery.
Gender	A person's sense of their own identity in relation to being a man or a woman, or identity beyond this conventional gender dichotomy – Richards and Barker, 2013
Gender Affirmation Surgery	See Surgery.
Gender Dysphoria	The formal diagnosis used by psychologists and physicians to describe people who experience significant dysphoria (discontent) with the sex and gender they were assigned at birth.
Gender Identity	A person's innate, deeply-felt psychological identification as a man, woman, or something else, which may or may not correspond to the person's external body or assigned sex at birth (i.e., the sex listed on the birth certificate).

	"Sexual identity" should not be used as a synonym for, or as inclusive of, "gender identity"
Gender Identity Disorder	According to DSM-IV-TR, Gender Identity Disorder is the diagnosis used when a person has (1) a strong and persistent cross-gender identification and (2) persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex, and the disturbance (3) is not concurrent with physical intersex condition and (4) causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Gender bender, Bi- gender, Beyond binary, Gender fluid, Gender outlaw, Pan gender, Polygender	Similar to genderqueer and androgyne, these terms refer to gender variations other than the traditional, dichotomous view of male and female. People who self-refer with these terms may identify and present themselves as both or alternatively male and female, as no gender, or as a gender outside the male/female binary.
Gender queer	Gender identities that are not exclusively masculine or feminine.
Gender reassignment surgery	See Surgery.

Gender-fluid	A gender identity which refers to a gender which varies over time.
Gender-queer (GQ)	This term is generally used in two ways: (1) as an umbrella term that includes all people whose gender varies from the traditional norm, akin to the use of the word “queer” to refer to people whose sexual orientation is not heterosexual only; or (2) to describe a subset of individuals who are born anatomically female or male, but feel their gender identity is neither female or male.
Gender-variant	A behavior or gender expression by an individual that does not match masculine and feminine gender norms.
Genderless	The state of having no gender identity, regardless of physical sex.
Genital reconstruction surgery	See Surgery.
Glansplasty	Surgical procedure to construct the glans penis, which is the sensitive and bulbous structure at the tip of the penis.
Hypnosis	The induction of a state of consciousness in which a person seems to loose the power of voluntary action and is highly responsive to suggestion or direction. Its use in therapy, is typically to recover suppressed memories or to allow modification of behaviour.
Hysterectomy	The surgical removal of the uterus.

Labiaplasty	Plastic surgery procedure for altering the labia minora and the labia majora, the folds of skin surrounding the human vulva.
Mastectomy	Surgical removal of one or both breasts, partially or completely.
Neutrois	A non-binary gender identity that falls under the genderqueer or transgender umbrellas. each person that self-identifies as such experiences their gender differently. The most common ones are: Neutral-gender Null-gender Neither male nor female Genderless Agender
Non-binary	Non-binary gender describes any gender identity which does not fit within the binary of male and female.
Oophorectomy,	The surgical removal of an ovary or ovaries.
Orchiectomy	The surgical procedure in which one or both testicles are removed.
Passing	If someone is regarded, at a glance, to be a cisgender man or cisgender woman. Cisgender refers to someone whose gender identity

	matches the sex they were 'assigned' at birth. This might include physical gender cues (hair or clothing) and/or behaviour which is historically or culturally associated with a particular gender.
Penectomy,	Penis removal through surgery.
Phalloplasty	Construction or reconstruction of a penis, or the artificial modification of the penis by surgery.
Reparative therapy	See conversion therapy
Queer Theory	Query theory (QT) is a theory that proposes that preferences are constructed, rather than pre-stored and immediately retrievable, as assumed by many economic models) by individuals in accordance with the answers to one or more internally posed questions, or queries.
Salpingectomy	The surgical removal of a Fallopian tube.
Sexual Orientation	Sexual orientation is understood to refer to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender
Stealth	When a transgender person who has transitioned into a different sex or gender does not divulge the fact of transition. When a person has gone through gender affirmation and does not disclose that fact to others.
Surgery	Numerous terms are used to describe the genital surgeries that some people may undergo, including "gender

	affirmation surgery" (GAS), "gender reassignment surgery" (GRS), "genital reassignment surgery" (GRS), "genital reconstruction surgery" (GRS), "genital surgery" (GS), and "sex reassignment surgery" (SRS). The foregoing terms are purposely listed in alphabetical order in view of the strong feelings some people have with respect to what is the right or better term to use; clinicians should listen to their clients to see which terms they prefer.
Scrotoplasty	Also known as oscheoplasty, is reparative or plastic surgery of the scrotum. As part of the surgical options for trans men, scrotoplasty is one of several operations performed to transform/reform the external genitalia into a penis and a scrotum
Third-gender	Third gender or third sex is a concept in which individuals are categorized, either by themselves or by society, as neither man nor woman. It also describes a social category present in those societies that recognize three or more genders.
Trans-feminine	A term used to describe transgender people who were assigned male at birth, but identify with femininity to a greater extent than with masculinity
Trans-masculine	A term used to describe transgender people who were assigned female at birth, but identify with masculinity to a greater extent than with femininity

Transgender	An umbrella term for people whose gender identity and/or gender expression differs from their assigned sex at birth (i.e., the sex listed on their birth certificates). Some groups define the term more broadly (e.g., by including intersex people) while other people define it more narrowly (e.g., by excluding "true transsexuals").
Transition	The process that people go through as they change their gender expression and/or physical appearance (e.g., through hormones and/or surgery) to align with their gender identity. A transition may occur over a period of time, and may involve coming out to family, friends, co-workers, and others; changing one's name and/or sex designation on legal documents (e.g., drivers' licenses, birth certificates); and/or medical intervention.
Transman	Generally refers to someone who was identified female at birth but who identifies and portrays his gender as male. People will often use this term after taking some steps to express their gender as male, or after medically transitioning. Some, but not all, transmen make physical changes through hormones or surgery.
Transsexual	People whose gender identity differs from their assigned sex at birth (i.e., the sex listed on their birth certificates).
Transwoman	Generally refers to someone who was identified male at birth but who identifies and portrays her gender as female. People will often use this term after taking some steps to

	express their gender as female, or after medically transitioning. Some, but not all, transwomen make physical changes through hormones or surgery.
Tucking	Pushing the testes into the inguinal canal and securing the penis back between the legs with gaff, an undergarment that flattens any bulging
Two-spirited	People who display characteristics of both male and female genders. Sometimes referred to as a third gender – the male-female gender. The term is derived from the traditions of some Native North American cultures. Two Spirit also means a mixture of masculine and feminine spirits living in the same body. This term also represents the self-identity description used by many Native American gay men who do not identify as cross-gendered or transgender.
Urethral reconstruction	**Surgical** procedure for urethral reconstruction
Urethroplasty	Surgical procedure to repair an injury or defect within the walls of the urethra.
Vaginectomy	Surgical procedure to remove all or part of the vagina.
Vaginoplasty	Surgical procedure that results in the construction or reconstruction of the vagina.
Mayhem Statute'	A common law criminal offense consisting of the intentional act of disabling, maiming or disfiguring another person. In England and Wales and other common

	law jurisdictions it originally consisted of the intentional and wantion removal of a body part that would handicap a person' ability to defend himself in combat
Hippocratic Oath	The Hippocratic Oath is an oath historically taken by physicians.
M-t-F	Male-to-Female
F-t-M	Female-to-Male

Appendix B – Conferences/Presentations

Trans Form Cymru Conference, November 2015, Margem, United Kingdom*

1) Mental Health
2) Self-harm and Suicide awareness

Personality Disorder Network Conference, July 2012, Cardiff, United Kingdom

Self-Harm Management Programme in Prison

Co-authored with Dr. Julia Rose

International Council of Psychologists 68th Annual Conference, August 2010, Chicago, United States

Challenges of Self-harm Behaviour in Forensic Settings

Co-authored with Dr. Julia Rose

International Council of Psychologists 69th Annual Conference August 2011, Washington, United States

Challenges of Working in with Self-harm in Forensic Settings

Co-authored with Dr. Julia Rose

Annual Progress Review Conference, May 2013, Wolverhampton University, United Kingdom

Therapists 'perspectives on transgender clients' vulnerability towards

suicide

Counselling in Prisons 6th Annual Conference, June 2013, Birmingham University, United Kingdom

Self-harm in the Prison Service

British Psychological Society, Division of Counselling Psychology Annual Conference, July 2013, Cardiff, United Kingdom

Therapists 'perspectives on transgender clients' vulnerability towards

Suicide

Counselling in Prisons 7th Annual Conference, July 2014, Durham University, United Kingdom

Working with Personality Disorder

Appendix C – Search Terms

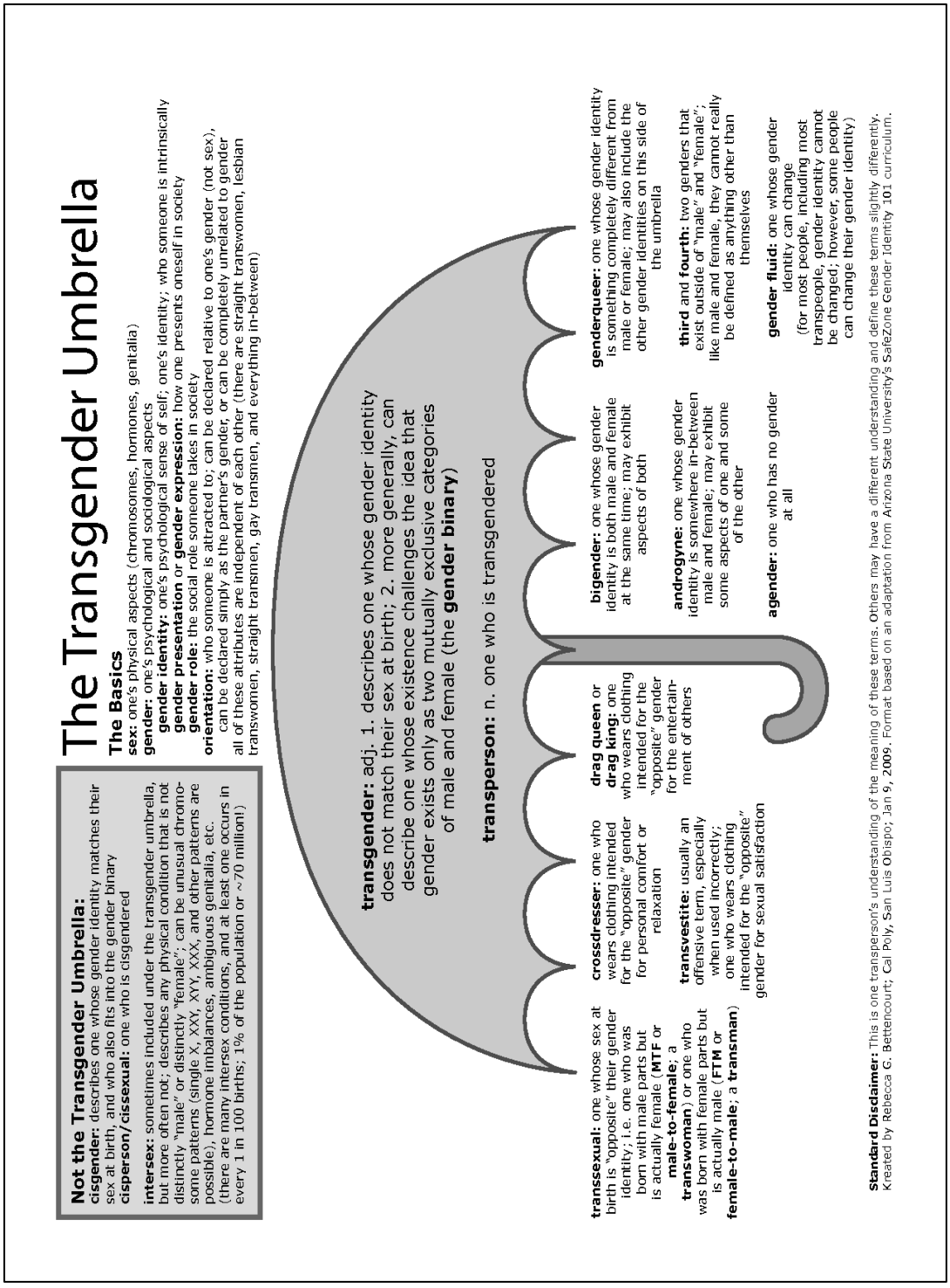
Key terms used included: **Trans*** *and variations including transgender, transgenderism and Transgendered,* gender-variant, gender-fluid, non-binary, gender identities. *gender norms, gender expression,* gender spectrum'*;* ***Self-harm*** *and its derivatives including deliberate self-harm, self-injurious behaviours, self-attacking behaviours, chest binders, chemsex, parasuicide, self-castration, and genital mutilation and risk-taking behaviours;* ***Suicide*** *- suicide ideation, suicidal ideation;* ***Identity*** *– gender identity, gender identity dysphoria, gender dysphoria, identity, gender transition Lesbian, Gay, Bisexual and Transgender and LGBT;* ***Approaches*** - reparative therapy, affirmative therapy, *aversion treatment,* conversion therapy *intimidation, electroconvulsive therapy, sensory deprivation, psychoactive medications;* ***Surgery*** - *gender affirmation surgery*), *gender reassignment surgery, genital reassignment surgery, genital reconstruction surgery, genital surgery* and *sex reassignment surgery;* ***Diagnosis*** - Gender Identity Disorder of Childhood, Gender Identity Disorder of Adolescence and Adulthood, Non-transsexual Type and Gender Identity Disorder Not Otherwise Specified

Additional terms include access to care, accessing services, attitudes, barriers to services/therapy, best practice, bias challenges, clinical training, continuing professional development, coping strategy, core competencies, counselling psychology, counselling, cultural competency, discrimination, distress, distrust, domestic abuse, gatekeepers, guilt, healthcare, Hippocratic Oath, human rights, identity, incongruence, inequality,informed consent, internal world', language, life-course, life-span, Mayhem Statute, medical model, mental health, minority stress, minority voices, Nursing, nursing attitudes, positive/negative experiences, practice guidelines, professional standards and policies, psychological well-being, psychology, public health, reflexivity, relationships, risk

management, secondary gains, shame, silent majorities, social gender norms, standards of care, stigma, therapeutic alliance, therapeutic considerations, therapeutic frameworks, therapeutic, training programmes, transgender community, transition and violations.

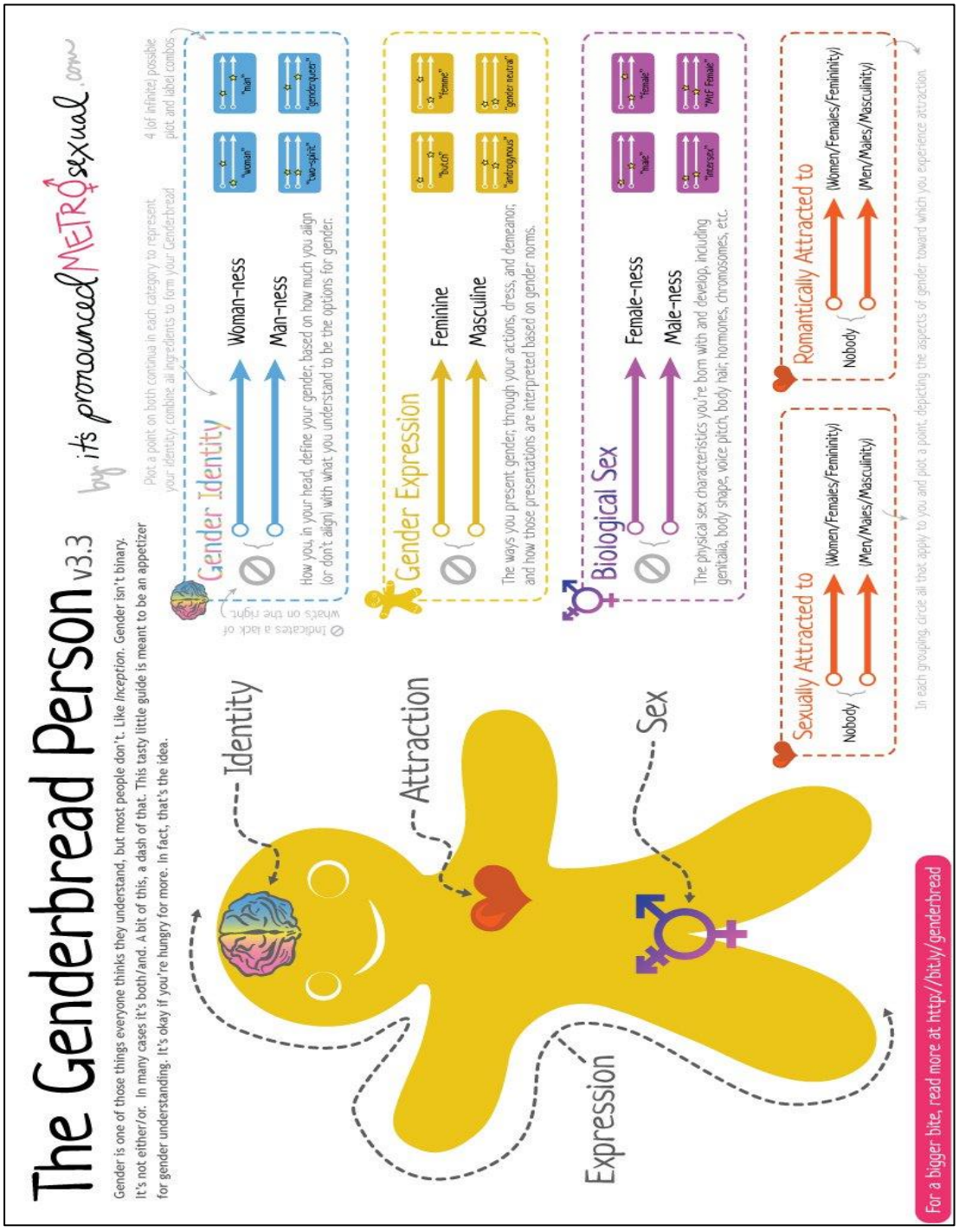
Appendix D – Transgender Umbrella Term Infographic

Transgender Definition as an umbrella term, Reprinted from 'Yaygender', by R. Bettencourt, 2009. Retrieved from http://www.yaygender.net/localresources/TGUmbrella2-90.pdf



Appendix E – Genderbread Infographic

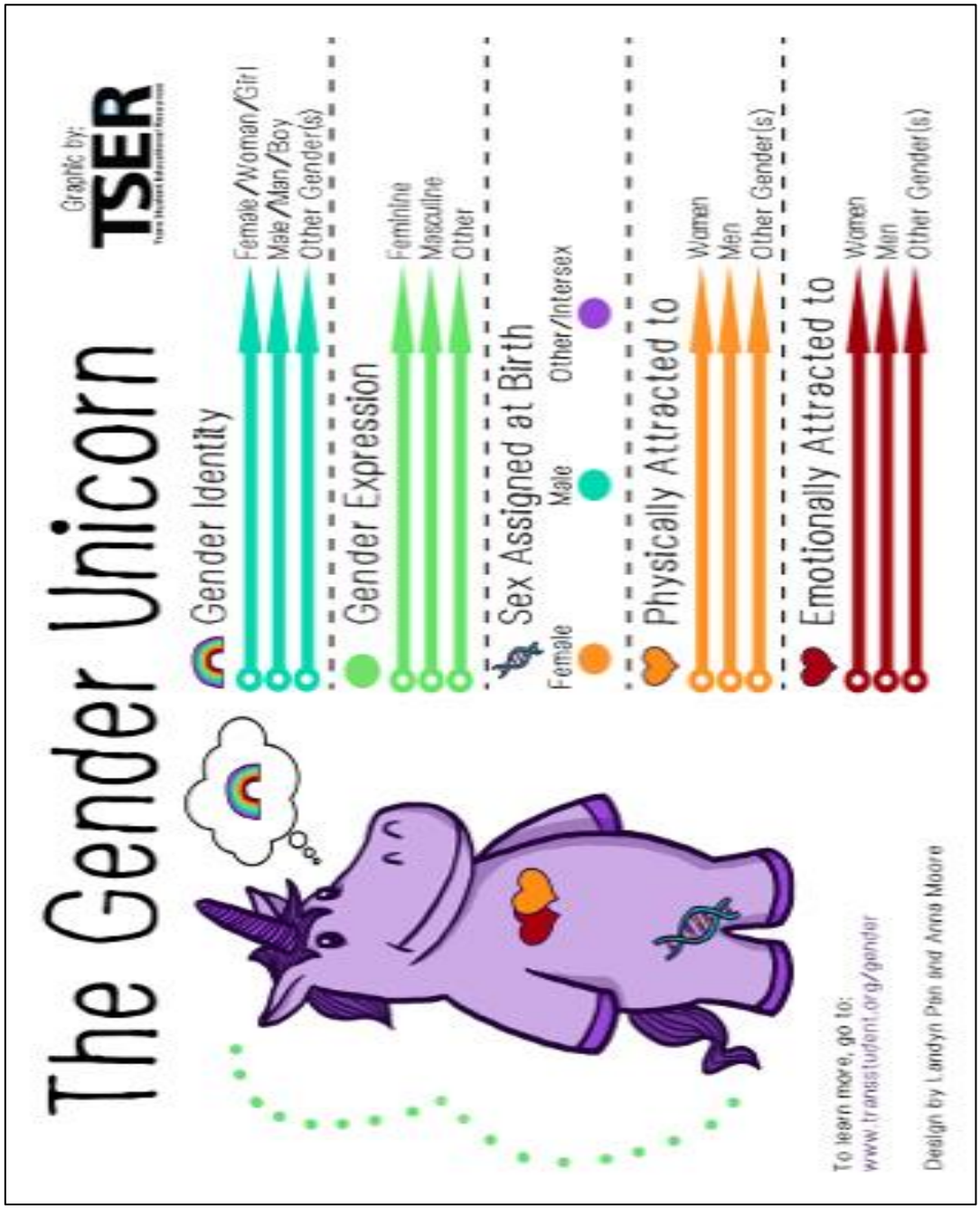
Genderbread Infographic taken from: www.itspronouncedmerosexual.com/2012/01/the-genderbread-person/



Appendix F – Gender Unicorn Infographic

Gender Unicorn Infographic taken from:

http://apps.naspa.or/cfp/uploads/genderunicorn1.pdf



Appendix G – Participant Information Sheet

UNIVERSITY OF WOLVERHAMPTON

PARTICIPANT INFORMATION SHEET

Therapists' perspectives on transgender clients' vulnerability towards suicide

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and ask questions if anything you read is unclear or you would like more information. Take time to decide whether or not you wish to take part.

This research is for a Practitioner Doctorate in Counselling Psychology

Purpose of study

At present research pertaining to transgender remains in its infancy with areas yet to be explored in depth. The purpose of this research is to explore therapists' perspectives for the possible underlying reasons of continued suicidal ideation and suicidal attempts (including self-harm) in transgender clients' post- gender realignment surgery.

It is hoped this research will yield information which will provide a better understanding of the high rates of continued suicidal ideation and suicide attempts amongst transgender clients who have undergone gender realignment surgery.

Why have I been chosen?

You have been invited to participate in this research because you have experience of working with transgender clients who have undergone gender realignment surgery. There will be seven participants in this research.

Do I have to participate?

Participation in this study is voluntary, and you are under no obligation to take part. If you agree to participate in the research, you will be asked to sign a consent form. You can decide to stop being part of the research at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn / destroyed

What will participation involve?

If you decide to take part, you will take part in an interview at a time convenient to yourself via Skype. The interview will be based around a semi structured interview schedule and take approximately 60 minutes. It is intended as an opportunity for you to express your perspectives on the vulnerability of transgender clients towards suicide. The interview will be digitally tape recorded, and later transcribed into text form. Recordings of interviews will be deleted upon transcription.

What if I have a problem or concern?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. **Research supervisor**: Dr. Richard Darby at the School of Applied Sciences, University of Wolverhampton, MC Block, Wulfruna Street, Wolverhampton, UK. WV1 1LY (email: [redacted] or myself [redacted].

Will my taking part in this study be kept confidential?

Yes. All information about you and the things you say will be kept confidential. The transcription of the interviews you participate in will be stored on a password-protected computer in a locked office. Only the researchers working on the project will have access to the information. Lisa Gray will be the custodian of the data.

What do I do now?

If you are interested in taking part in the study, you are asked to complete the attached consent form and return it to me by **/**/** via email me at [redacted]. Once I have received the form I will contact you so we can arrange to meet at a time that is convenient for you. If you decide not to participate in the study you need not return the response slip and no further contact will be made.

This is your copy of the information sheet to keep

Thank you for taking the time to read this sheet

Appendix H – Participant Consent Form

UNIVERSITY OF WOLVERHAMPTON

PARTICIPANT CONSENT FORM

Title:

Therapists' perspectives on transgender clients' vulnerability towards suicide

Please tick the box if you agree with the statement to the left

I confirm that I have read and understand the information sheet for Research Participants for the above study	☐
I have had the opportunity to ask questions about the research	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. If I decide to withdraw I understand that any information I have given will be destroyed and none response included in the research	☐
I understand that if I agree to participate in this research I am agreeing to take part in a semi-structured interview with the Researcher which will be audio-recorded	☐
I understand that my responses will be kept strictly confidential	☐
I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	☐
I give permission for members of the research team and examiners to have access to my anonymised responses.	☐
I understand that I will be interviewed about my experiences of therapeutic clients who have had GRS, with special reference to suicide and self-harm	☐
I agree to take part in the above research project.	☐

Name of Participant	Date	Signature
Researcher (Lisa Gray)	Date	Signature

Appendix I – Research Proposal

Researcher: Lisa Gray

Supervisor: Prof. Ken Mankletow

Second Supervisor: Dr. John Bergin

Current Supervisor: Dr. Richard Darby

Working title: Therapists' perspectives on transgendered clients' vulnerability towards suicide

Rationale and Anticipated Outcomes

The topic of transgender / transsexualism has been widely debated since the first male-to-female sex reassignment surgery (SRS) was performed in Germany in 1930 under the supervision of Dr. Magnus Hirschfeld. The initial operation consisted of five separate operations; a pentectomy (removal of penis), orchiectomy (removal of testicles and spermatic cord), transplantation of ovaries, two to remove the ovaries after transplant rejection, and vaginoplasty (construction of vaginal canal and mucous membrane). The patient died three months after the fifth operation. The first successful SRS was completed in 1952 in Denmark. In the UK, since 2000 there have been 856 sex reassignment surgeries completed.

Due to the continuing metamorphosis of transgenderism in relation to social acceptance, legal reforms, availability of surgery and psychological exploration into the advantages and disadvantages of sex reassignment surgery the associated body of literature is in its infancy particularly in the UK (Press for Change, 1998; Brown &

Rounsley, 2003; Johnson, Mimiaga & Bradford, 2008). Nevertheless, there is a plethora of literature published on transgender from autobiographical, familial, medical and scientific perspectives which fail to address the 'human element' and adequately explore the psychological components (Brown & Rounsley, 2003). However, one area which is yet to be comprehensively researched is the high level of self-harm and suicide amongst post-operative transgender individuals.

The aim of this research is to explore an area of transgenderism which is yet to be comprehensively investigated. At present, the level of suicide attempts in post-operative transgendered individuals in the UK stands at 34% and 41% in the United States. Research suggests that, an even higher proportion continue to self-harm post-sex reassignment surgery. Due to the high correlation between self-harm and suicide in the general population, the research will aim to uncover the function of self-harm for pre-and post-operative transgendered individuals with the aim of identifying precursors to suicide. Difficulties arise in obtaining true statistics as a person's death certificate does not note if a person was transgender, therefore statistics can only be obtained from transgender support services. Further difficulties arise in relation to cultural views of suicide and the stigma attached which subsequently affects suicide statistics and thus their true reflection of the problem within transgenderism.

Approach

A Foucauldian Discourse Analysis (FDA) qualitative approach will be used with this research, focusing on how aspects of society are constructed by language, understanding and views of the world, categorisations, relationships and ultimately the power relationships that ensue (Given, 2008). The research focus will be on the subjective, contextualised experiences and actions of clinicians who have worked / are working with

clients' post- gender reassignment surgery and who continue to experience suicidal ideation and / or suicide attempts.

Data Collection and Analysis

Semi-structured interviews will be used as they permit a degree of freedom in terms of the order in which an issue is discussed and allow the participants to explore the topic in their own way. Furthermore, the open-ended dialogue between researcher and participant allows for manoeuvrability and exploration of additional pertinent issues that arise throughout the interview. The advantage of using semi-structured interviews is through the exploration of unforeseen answers which can reveal new perspectives to the question thus producing rich and authentic data (Breakwell, Hammond, Fife-Schaw & Smith; 2006). All interviews will be recorded with a digital audio recorder and once completed will be transcribed in a typewritten format ensuring that protocol anonymity and confidentially is maintained throughout. Following transcription, the process of analysis will begin using identified six steps in the analysis of Foucauldian Discourse Analysis; discursive constructions, discourses, action orientation, positioning, practice and subjectivity as laid out by Carla Willig (Introducing Qualitative Research in Psychology: Adventures in Theory and Method, 2001 / 2008).

The interviews will take place in a safe and convenient location to both the researcher and participant. This may include the participants own office or an appropriate room at Wolverhampton University. The researcher will ensure that another person knows the time and location of the interview to ensure their safety.

Participants

It is anticipated there will be seven participants each of whom will be interviewed in relation to their own professional capacity and not their role within any NHS trust. To da,te three clinicians have agreed to take part in the research. The rationale for choosing seven participants is due to the methodology itself, the approach is concerned with language and its role in the constitution of social and psychological life and its subsequent implications including power differentials. Therefore, it does not require saturation of a large number of participants. The important aspect is the language used and the subjective, contextualised experiences and actions of the clinicians which will be thoroughly analysed using Foucauldian Discourse Analysis. The number of participants may increase depending on the information and discourse gathered through the interviews.

Participants will be experienced clinicians e.g. psychiatrists, psychologists, counsellors who have had or are currently working with transgendered clients in a variety of settings within the UK for five or more years. No distinction will be made between the roles that the clinicians have with the transgendered person, as long as it is of a therapeutic nature e.g. psychiatrist, psychologist, counsellor. It is important that the clinicians are experienced in order to ensure that a true perspective of the challenges of working with this population is obtained and explored in depth. Clinicians have been identified as the most appropriate participants due to the nature of their therapeutic work, thus making it more probable that a client would disclose the continuation or onset of suicidal behaviour / ideation post-gender reassignment surgery. Furthermore, experienced clinicians will have a wider frame of reference to draw upon.

Participants will be recruited through support agencies / services offered available to transgender persons. The participants will be selected in terms of their experience of

working with transgender clients. The rationale for this recruitment process is because it is anticipated that these clinicians will have a broader range of experience and knowledge working with this client group. Furthermore, it is anticipated that as they work in support services / agenci,es they will have worked with a diverse range of transgender clients varying in complexity, thus providing rich data.

Sampling strategies employed include initially contacting seven prospective participants, if any decline to take part then further prospective participants will be contacted, it is hoped this will reduce the likelihood of snowballing. The information sheet which will be sent out to each prospective participant outlines the study and explicitly states that the research is focused on suicidal behaviour and suicidal ideation (including self-harm) post-gender reassignment surgery. It is anticipated that any clinicians who have not worked with clients exhibiting or presenting with such difficulties, will decline to participate in the research.

Ethics

The participants involved will be over the age of 18 and not classified as vulnerable. Ethical guidelines as stipulated by the British Psychological Society's code of ethics (2009) will be adhered to throughout. Due to the sensitive nature of the research, a cautious approach has been adopted and the appropriate forms completed for the School Ethics board. Furthermore, the IRAS process for NHS ethical approval in the event that some clinicians may have a role within the NHS will be undertaken.

Consent

Informed consent will be gained by exploring the issues outlined below, with each item being explained, understood and agreed by the participant before any research takes place.

Please see appendix 2 for the information sheet. Consent to participate in this study will be assessed by the researcher checking that the participants have a clear understanding of consent given. Please see Appendix 3 for the Participant Consent Form.

Data Protection / Storage

Data protection: all participants involved in the research will have all identifiable information changed e.g. names, roles and organisations associated with and so forth to ensure anonymity and privacy. Confidentiality will also be adhered to, with all recorded information, written and audio material being kept in a locked, safe and secure place, accessible only to the researcher, her supervisor and the participants themselves, should they wish.

Right to withdraw

Participants will be informed of their right to withdraw from the research at any time; this will include all materials and data collected from the participants. Furthermore, should they choose to withdraw that there will be no negative consequences. Participants will be given clear instructions as to how they can withdraw and have the full contact details of the researcher.

Avoiding harm

The research questions are open-ended and rely on the participants speaking about their own experiences of working with clients who have undergone gender reassignment surgery. Should any risk disclosure be make, the participant will be made aware that

information will be passed onto to a third party as stipulated in the BPS code of ethics and conduct (2009).

De-briefing / Feedback

A full debriefing of the research will be given to each participant at the end of the interview. Each participant will be informed about the use of the data provided and published. They will be provided with the researchers' contact details should they wish to have feedback on the research outcomes.

Materials

All interviews will be recorded with a digital audio recorder and once completed will be transcribed in a typewritten format. The transcribed interview documents will then be used to commence analysis.

Procedure

All participants will be briefed on the aims and objectives of the study and the role of their information / data in the research. Participants will be informed of the confidentiality of their information supplied, right to withdraw and how to access feedback on the research should, they require it once completed.

Participants will be interviewed individually and each interview will take between approximately 60 and 90 minutes and can include a break should the participant wish. The interview will be semi-structured, consisting of open-ended questions with prompts.

Following completion of the interview, each participant will be debriefed and given the researchers contact detail to receive further information about the research results or wish to withdraw their information from the research.

References

Breakwell, G., Hammond, S. M., Fife-Schaw, C. & Smith, J. A. (2006). *Research Methods in Psychology (3rd ed)*. SAGE Publication Ltd

British Psychological Society (2009). *Code of Ethics and Conduct*. British Psychological Society

Brown, M. L. & Rounsely, C. A. (2003). *True Selves: Understanding Transsexualism – For Families, Friends, Coworkers, and Helping Professionals*. Jossey-Bass: San Francisco.

A Wiley Imprint http://en.wikipedia.org/wiki/Foucauldian_discourse_analysis - cite_ref-Given2008_1-3#cite_ref-Given2008_1-3

Given, L. M. (2008). *The Sage encyclopaedia of qualitative research methods*. SAGE Publications

Johnson, C. C., Mimiaga, M. J. & Bradford, J. (2008). Health care issues among lesbian, gay, bisexual, transgender and intersex (LGBTI) populations in the United States. *Journal of Homosexuality*, 54 (3):213-24

National Centre for Transgender Equality. (2009). *Transgender Terminology* [Brochure]. Washington

Press for Change, (September 1998). Surgical Gender Reassignment for male-female transsexual people. Retrieved on 15th January 2011. Accessed via http://www.pfc.org.uk

Willig, C. (2008). *Introducing Qualitative Research in Psychology (*2nd edition). Open University Press

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and* Method (1st edition). Open University Press

Appendix J – Research Proposal Approval

University of Wolverhampton INTERNAL MEMORANDUM

School of Applied Sciences Extn: 1129
MA135
City Campus Email: [redacted]

To : Dr J Bergin, Prof K Manktelow & Lisa Gray

From: [redacted] Research Administrator

Date: 11th January 2012

Notification of decision of the RIHS Student Management Board held on 18th December 2012

Research Proposal

Student: Lisa Gray

I am pleased to advise you that the above proposal was approved.

Regards,
[redacted]

[redacted]
Research Administrator
Research Institute in Healthcare Science
School of Applied Sciences
University of Wolverhampton
Wulfruna Street
Wolverhampton

Appendix K - Completed Res20B Ethical Approval Form

UNIVERSITY OF WOLVERHAMPTON

RES 20B
(October 2003)

School of Applied Sciences Ethics Committee: submission of project for approval

To be completed by SEC:
Date Received:
Project No:

- **This form must be word processed – no handwritten forms can be considered**
- **ALL sections of this form must be completed**
- **No project may commence without authorisation from the School Ethics Committee**

CATEGORY B PROJECTS:

There is identifiable risk to the participant's wellbeing, such as:

- significant physical intervention or physical stress.
- use of research materials which may bring about a degree of psychological stress or upset.
- use of instruments or tests involving sensitive issues.
- participants are recruited from vulnerable populations, such as those with a recognised clinical or psychological or similar condition. Vulnerability is partly determined in relation to the methods and content of the research project as well as an *a priori* assessment.

All Category B projects are assessed first at subcommittee level and once approved are forwarded to the School Ethics Committee for individual consideration. Undergraduates are not permitted to carry out Category B projects.

Title of Project:	**Therapists' perspectives on transgendered clients' vulnerability towards suicide**
Name of Supervisor: (for all student projects)	**Dr. John Bergin** **Professor Ken Manktelow**
Name of Investigator(s):	**Lisa Gray**
Level of Research: (Module code, MPhil/PhD, Staff)	**Practitioner Doctorate**
Qualifications/Expertise of the investigator relevant to the submission:	**BSc (Hons) Psychology**

Participants: Please indicate the population and number of participants, the nature of the participant group and how they will be recruited.	It is anticipated there will be seven participants. They will be experienced clinicians (psychiatrist, psychologist, counsellors) who are currently working with transgendered clients in a variety of settings within the UK for five or more years. No distinction will be made between the roles that the clinicians have with the transgendered person, as long as it is of a therapeutic nature. It is important that the clinicians are experienced in order to ensure that a true perspective of the challenges of working with this population is obtained and explored in depth. In addition, experienced clinicians will have a wider frame of reference to draw upon. Participants will

	be recruited through support agencies / services offered for transgender persons.

Continued overleaf

Please attach the following and tick the box provided to confirm that each has been included::

Rationale for and expected outcomes of the study	**X**
Details of method: materials, design and procedure	**X**
Information sheet* and informed consent form for participants **to include appropriate safeguards for confidentiality and anonymity*	**X**
Details of how information will be held and disposed of	**X**
Details of if/how results will be fed back to participants	**X**
Letters requesting, or granting, consent from any collaborating institutions	**X**
Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16	**N/a**
Is ethical approval required from any external body? No **If yes, which Committee?** *NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.*	

Signed: Lisa Gray (Investigator) Date: 05/12/12

Signed: _____ (Supervisor) Date: _____

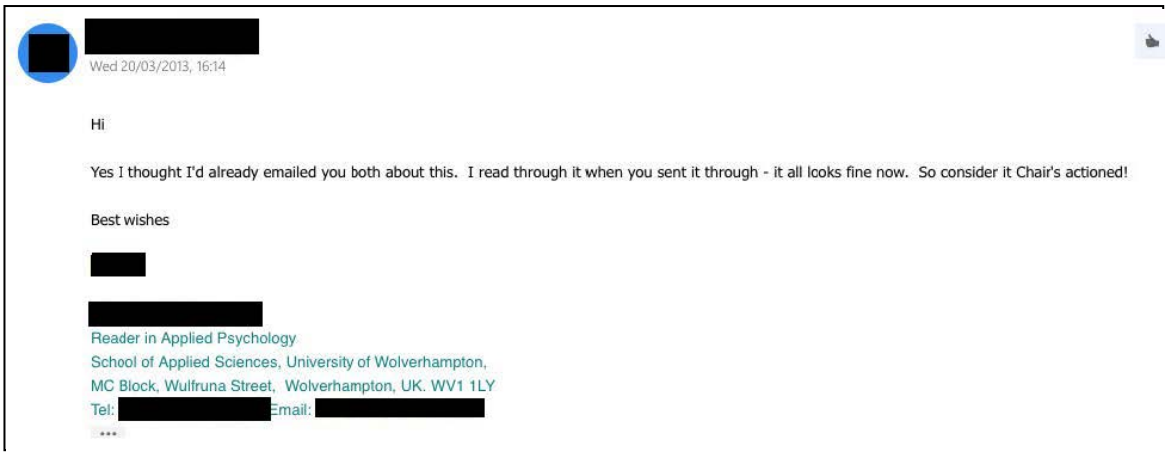
Except in the case of staff research, all correspondence will be conducted through the supervisor.

FOR USE BY THE SCHOOL ETHICS COMMITTEE

Divisional Approval Granted: _____ (Chair of Behavioural Sciences Ethics Committee) Date:

School Approval Granted: _____ (Chair of School Ethics Committee) Date _____

Appendix L - Ethical Approval



[redacted]
Wed 20/03/2013, 16:14

Hi

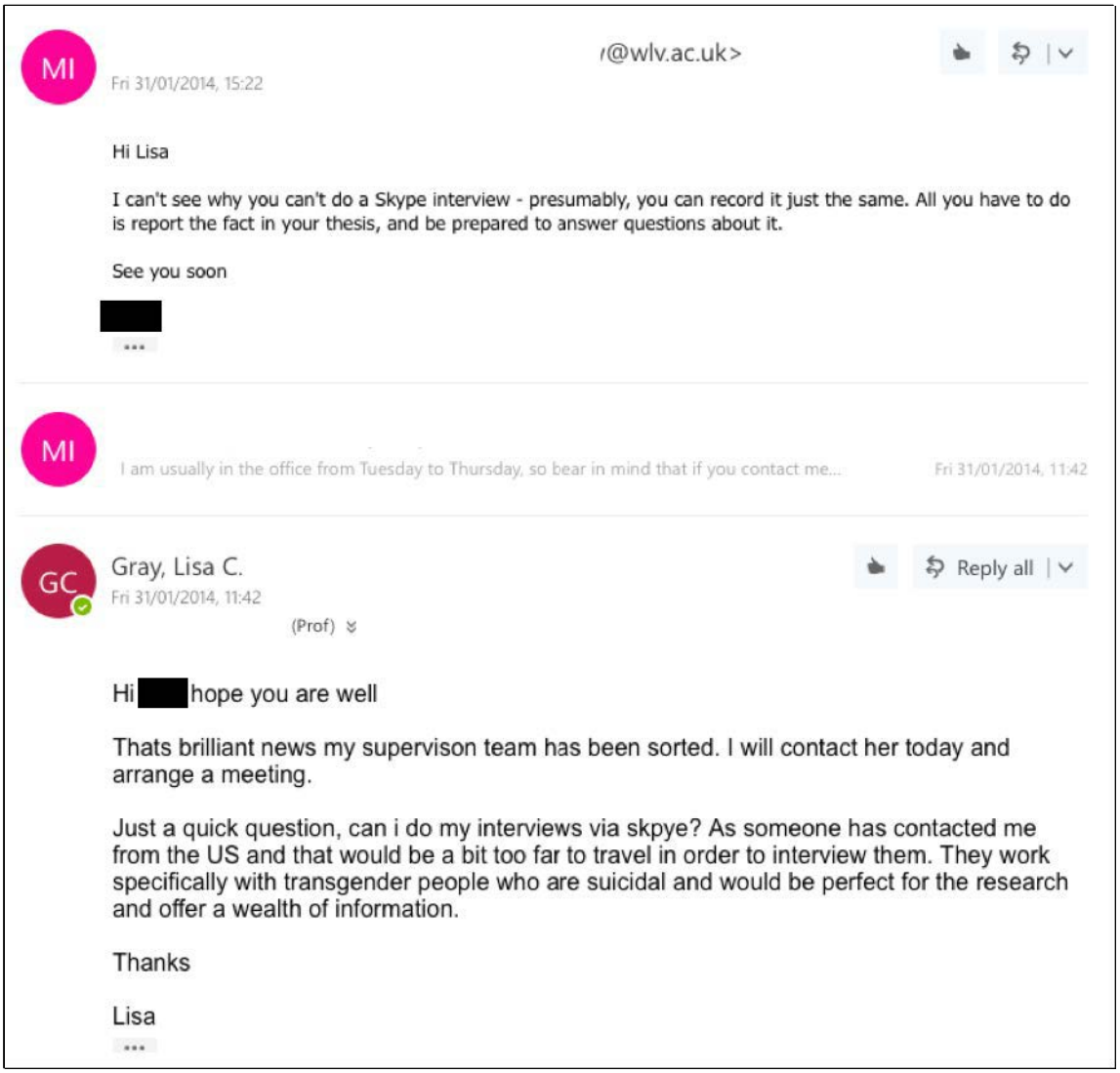
Yes I thought I'd already emailed you both about this. I read through it when you sent it through - it all looks fine now. So consider it Chair's actioned!

Best wishes

[redacted]

[redacted]
Reader in Applied Psychology
School of Applied Sciences, University of Wolverhampton,
MC Block, Wulfruna Street, Wolverhampton, UK. WV1 1LY
Tel: [redacted] Email: [redacted]

Appendix M – Agreement to contact overseas participants



MI

r@wlv.ac.uk>

Fri 31/01/2014, 15:22

Hi Lisa

I can't see why you can't do a Skype interview - presumably, you can record it just the same. All you have to do is report the fact in your thesis, and be prepared to answer questions about it.

See you soon

[redacted]

...

MI

I am usually in the office from Tuesday to Thursday, so bear in mind that if you contact me... Fri 31/01/2014, 11:42

GC

Gray, Lisa C.

Fri 31/01/2014, 11:42

Reply all

(Prof)

Hi [redacted] hope you are well

Thats brilliant news my supervison team has been sorted. I will contact her today and arrange a meeting.

Just a quick question, can i do my interviews via skpye? As someone has contacted me from the US and that would be a bit too far to travel in order to interview them. They work specifically with transgender people who are suicidal and would be perfect for the research and offer a wealth of information.

Thanks

Lisa

...

Appendix N - Transcript Key

Symbol	**Meaning**
Lisa	Researcher
###	Inaudible
…	Pauses
[Laugh]	Non-verbal utterance
[Cough]	Non-verbal utterance
[Crosstalk]	Researcher and participant talking over each other
Location, Names, Places of Work, colleagues, friends	Removed identifying details, during transcription process.

Appendix O - Interview Questions

- ◊ Can you please describe your experience of working with transgender clients and in what capacity?
- ◊ What is your experience of working with transgender clients who have had suicidal ideation or made suicide attempts post- gender reassignment surgery?
- ◊ What is your perspective on the reason for the high percentage of suicide attempts post-surgery?
- ◊ In relation to your therapeutic practice are you aware of any differences in the approach and focus of interventions you use with your clients' pre- and post-surgery
- ◊ Have you witnessed any 'changes' in clients post- surgery in relation to their approach / requests from the service, which could indicate a possible vulnerability towards suicide
- ◊ Have you experienced clients who have changed their interaction with the service post-surgery and not disclosed a continuation of difficulties, despite yourself noting them? If so how has this been addressed?
    - Do you feel this affects the therapeutic relationshop
- ◊ When working with transgender clients' as a therapist, do you feel there is anything missing in the services provided / available?
- ◊ As a therapist, what is your view on the current services provided for transgender clients, post- surgery?
- ◊ Do you believe that the services available currently meet the needs of transgender clients? If so how do they or how don't they?
- ◊ Is there anything else you would like to add?

Appendix P – Word Cloud – Claire

Appendix Q – Word Cloud – Henry

Appendix R – Word Cloud – Kaye

Appendix S – Word Cloud – Martin

Appendix T – Word Cloud – Mary